JAMAICA

Country Progress Report

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GLOBAL AIDS RESPONSE PROGRESS REPORT

2014

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Acronyms

AHF	AIDS Healthcare Foundation
AIDS	Acquired Immunodeficiency Syndrome
ANC(s)	Antenatal clinic(s)
ART	Antiretroviral therapy
ARV	Antiretroviral
BCC	Behaviour Change Communication
BSS	Behavioural Surveillance Surveys
CARPHA	Caribbean Public Health Agency
CDC	Centers for Disease Control and Prevention
CHAI	Clinton Health Access Initiative
CVC	Caribbean Vulnerable Communities
EEHR	Enabling Environment and Human Rights
EMTCT	Elimination of mother-to-child transmission
ERTU- CHART	Epidemiology Research and Training Unit of the Caribbean HIV/AIDS Regional Training Network
FBO	Faith Based Organization
GF	Global Fund to fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People Living with HIV
GOJ	Government of Jamaica
HEI	HIV Exposed Infants
HFLE	Health and Family Life Education
HIV	Human Immunodeficiency Virus
IDP	International Development Partner
IEC	Information, Education and Communication
ILO	International Labour Organization
IMF	International Monetary Fund
IBRD/ World Bank	International Bank of Reconstruction and Development
HPP	Health Policy Project
JCTU	Jamaica Confederation of Trade Unions
JEF	Jamaica Employers Federation
LGBT	Lesbian, Gay, Bisexual and Transgender
MARP	Most at Risk Population
MEASURE	Monitoring and Evaluation to Assess and Use Results
MERG	Monitoring and Evaluation Reference Group
M&E	Monitoring and Evaluation
MFAFT	Ministry of Foreign Affairs and Foreign Trade
MIIC	Ministry of Industry Investment and Commerce
MLSS	Ministry of Labour and Social Security
MNS	Ministry of National Security
MOE	Ministry of Education

MOJ	Ministry of Justice
MOH	Ministry of Health
MOYC	Ministry of Youth and Culture
MSM	Men who have sex with men
MSTEM	Ministry of Science, Technology, Energy and Mining
MTCT	Mother-to-child transmission
NAC	National AIDS Committee
NASA	National AIDS Spending Assessment
NCDA	National Council on Drug Abuse
NCPI	National Commitments and Policy Instrument
NHDRRS	National HIV-Related Discrimination Reporting and Redress System
NHP	National HIV/STI Programme
NFPB	National Family Planning Board
NGO(s)	Non-governmental Organization(s)
NPHL	National Public Health Laboratory
NSP	National Strategic Plan
OVC	Orphans and Other Vulnerable Children
PAHO	Pan American Health Organization
PANCAP	Pan Caribbean Partnership against HIV and AIDS
PEPFAR	President's Emergency Plan for AIDS Relief
PHDP	Positive Health and Dignity Prevention
PIOJ	Planning Institute of Jamaica
PITC	Provider-initiated Testing & Counselling
PLACE	Priorities for Local AIDS Control Efforts
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
STI(s)	Sexually Transmitted Infection(s)
SW	Sex Workers
RHS	Reproductive Health Survey
TCI(s)	Targeted Community Interventions
TCS	Treatment, Care and Support
UMI	Upper Middle Income
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCP	Voluntary Compliance Programme
VCCT	Voluntary Confidential Counselling and Testing
VCT	Voluntary Counselling and Testing

Acknowledgements

The submission of Jamaica's Global AIDS Response Progress Report would not have been possible without the contributions and efforts of all stakeholders in the national response to HIV.

The Ministry of Health acknowledges the leadership of the National HIV/STI Programme (NHP) and the National Family Planning Board – Sexual Health Agency (NFPB-SHA) in the completion of this report. Sincere appreciation is extended to the members of the NCPI Interview Team for their commitment to a rigorous and transparent process and to the stakeholders who provided timely, accurate reporting of data and participated in the consultation and validation process. The Ministry of Health also wishes to acknowledge the financial and technical support of the UNAIDS, Jamaica, towards the preparation and submission of the report

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Status at a Glance

Country Profile

Jamaica is the largest English-speaking Island in the Caribbean with a land area of 10,991 square kilometres and a total population of 2,705,800 (STATIN 2010 population figures). The island is divided into fourteen parishes. The capital city, Kingston on the South East coast and Montego Bay on the North Coast are the two main urban centres. Jamaica is currently at an intermediate stage of the demographic transition. It has a declining 0-14 age group (9% of total population); and an increasing working age group (52%) and dependent elderly population (11%).

Jamaica's epidemiological profile is marked by a declining burden of communicable diseases and a considerable increase in non-communicable diseases. Despite this, HIV continues to play a significant role in morbidity and mortality level of the population and carries great financial and human resource cost to the health sector. Moreover, the epidemic threatens national productivity because the majority of cases occur in the reproductive and working age groups.

Since the first case of AIDS was identified in 1982, 30,620 cases of HIV have been reported to the Ministry of Health in Jamaica. All 14 parishes are affected by the HIV epidemic but the most urbanized parishes have the highest cumulative number of reported HIV cases (St. James – 2,195.9 HIV cases per 100,000 persons and Kingston & St. Andrew – 1,656.2 cases per 100,000 persons). Parishes with significant Tourism based economies have the next highest level of cumulative number of reported HIV cases since the start of the epidemic: ranging from 1053.5 per 100,000 persons in Trelawny to 1257.9 cases per 100,000 persons in St. Ann. See Figure 1.

According to 2014 models, approximately 1.8% of the adult population or 30,265 persons are living with HIV. Surveillance data show higher HIV prevalence in populations among men who have sex with men (MSM) (32.8%), female sex workers (SW) (4.1%), and homeless persons (12%) (Ministry of Health, 2012). The main drivers of the HIV epidemic are closely tied to poverty and related development issues, including the slow rate of economic growth, high levels of unemployment, low academic achievement, early sexual debut, multiple partnerships, and transactional and commercial sex.

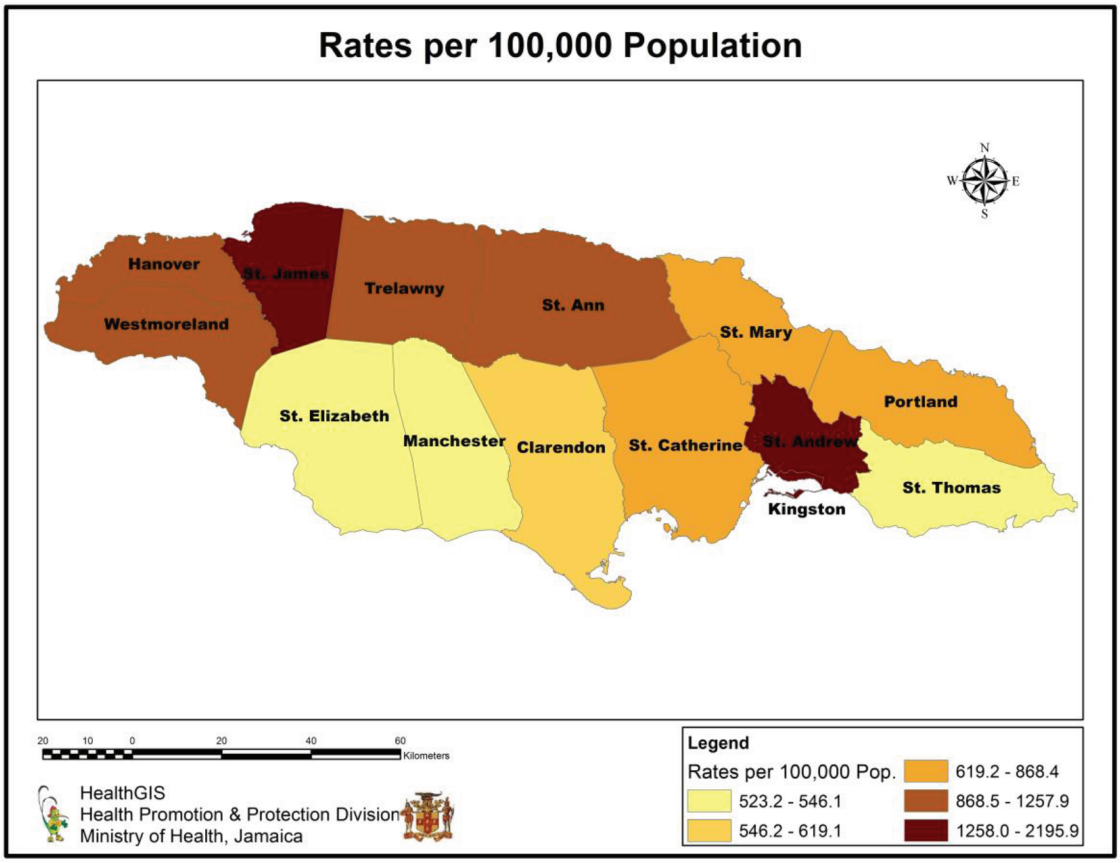


Figure 1. Cumulative reported HIV case rates per 100,000, 1982–2012

Jamaica's national response to the HIV epidemic is multi-sectoral and is guided by stakeholders from the Government of Jamaica, non-governmental organizations, civil society, private sector groups, international development partners, and persons living with HIV. The national response is guided by a 5 year national strategic plan developed around 6 priority areas: Prevention, Treatment, Care and Support, Enabling Environment and Human Rights, Empowerment and Governance, Monitoring & Evaluation, and Sustainability. In response to emerging epidemiological data, prevention strategies to reduce risk of infection in high-risk groups were scaled up significantly. Surveillance data for 2012 reveal the number of AIDS Deaths has decreased by 61% since the introduction of Universal Access to ARVs in 2004. The number of HIV tests done annually has almost doubled from less than 100,000 tests per year prior to 2004 to 248,311 in 2012, and 236,583 in 2013. The implementation of opt-out testing for pregnant women has resulted in nearly all pregnant women attending public clinics being tested for HIV and less than 1.9% mother to child transmission rate in 2013.

Inclusiveness of Stakeholders in the Report Writing Process

This document details trends in UNGASS indicators, the achievements and challenges of the Jamaica national HIV response, and future directions in order to achieve the vision of the national response. This report draws heavily on the *NSP 2012-2017, the 2013 Mid-Term Review Report, CARPHA End-of-Term Evaluation Report,* and the *Sustainability Framework Report*, which were developed through extensive consultations and with input from Stakeholders. The M&E Units of the National HIV Programme, Ministry of Health and the National Family Planning Board – Sexual Health Agency led the report writing process, data entry and national consultations with technical support from UN Partners. The compiled report was reviewed and edited based on stakeholder consultations.

The Jamaica country report will include the National Commitments and Policy Instrument. A consultant worked closely with a team of interviewers from Civil Society, Government and UNAIDS to conduct interviews with key stakeholders in the national response. Three stakeholder consultations, which involved 68 stakeholders, were held to review the process, validate the data and then provide feedback on the summary report.

A civil society representative facilitated the gathering of best practices by finalizing a response template, gathering submissions and preparing a summary report.

Indicator Data

TARGETS	INDICATORS		PERFORMANCE
Target 1. Reduce sexual transmission of HIV by 50% by 2015 *General population*	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: 39% Men: 35.6% Women: 42.8% (2012, KABP survey) 40.2%. (2008, KABP) Men: 37.4% Women: 42.3% (2008, KABP) Women: 59.8% (urban); 57.9% (rural) – (2005, Multiple Indicator Cluster Survey)/ 38.1% of 15-24 y.o (2004, KABP) Men: 22.8% Women: 46.7% (2004, KABP)
	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: 31.6% Men: 49%; Women: 12.5% (2012, KABP survey) Men: 56.6% Women: 15.9% (2008, KABP survey) Men: 47.7% Women: 11% (2004, KABP survey)
	1.3	Percentage of adults aged 15-49 who have had sexual intercourse with more than	Overall: 30.4%; Men: 47.2% Women: 13.6% (2012, KABP survey) Men: 61.5% Women: 16.8% (2008, KABP survey) Men: 48% Women: 11% (2004, KABP survey)

TARGETS	INDICATORS		PERFORMANCE
		one partner in the past 12 months [National Target: Men: 47% Women: 15% by 2008]	
	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: 61.1%; Men: 66.2% Women: 43.4% (2012, KABP survey) Men: 64.5% Women: 52.1% (2008, KABP survey) Men: 66.9% Women: 53.8% (2004, KABP)
	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: 59.1%; Men: 49.4% Women: 68.7% (2012, KABP survey) Men: 20.2% Women: 35.4% (2008, KABP survey) Men: 12.2% Women: 18.3% (2004, KABP Survey)
	1.6	Percentage of young people aged 15-24 who are living with HIV* [Target: 25% reduction in most affected	0.69% (2013, Sentinel surveillance of ANC clients) 0.67% (2012, Sentinel surveillance of ANC clients) 0.91% (2011, Sentinel surveillance of ANC clients) 0.78% (2010) Sentinel surveillance of ANC clients) 0.84% (2009, Sentinel surveillance of ANC clients)

TARGETS	INDICATORS		PERFORMANCE
		countries by 2005; 25% reduction globally by 2010] [National Target: ≤1.5% by 2009]	1.25% (2007, Sentinel surveillance of ANC clients) 1.53% (2005, Sentinel surveillance of ANC clients) 1.09% (2004, Sentinel surveillance of ANC clients)
Sex workers	1.7	Percentage of sex workers reached with HIV prevention programmes	79.7% SW (2011, Second generation surveillance) This indicator was not determined in Second generation surveillance of SWs in 2008. Based on BCC Programme data, over 10,000 SWs were reached in 2008 and 2009 60% SW (2005, 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) Regular client: 91%; New Client: 97% (2008, KABP survey) 84.2% (2005, 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) 75% SW (2008, Second generation surveillance) 43% SW (2005, Second generation survey)
	1.10	Percentage of sex workers	4.1% of SW (2011, Second generation surveillance) 5% of SW (2008, Second generation surveillance)

TARGETS	INDICATORS		PERFORMANCE
		who are living with HIV [National Target: ≤7% by 2011]	9% of SW (2005, Second generation surveillance)
Men who have sex with men	1.11	Percentage of men who have sex with men reached with HIV prevention programmes	87.41% (2011, Second generation surveillance) *Survey data overestimates reach, due to non random sample recruited through workshops and programme contacts. This indicator was not determined in Second generation surveillance previously. Based on BCC Programme data, over 4,000 MSMs were reached in 2008 and 2009
	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) 73% (2007, 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) 53% MSM (2007, Second generation surveillance)
	1.14	Percentage of men who have sex with men who are living with HIV	32.77% of MSMs (2011, Second generation surveillance) 32% (2007, Second generation surveillance)

TARGETS	INDICATORS		PERFORMANCE
		[National Target: <25% by 2011]	
Target 2. Reduce transmission of HIV among people who inject drugs by 50 percent by 2015		Not Applicable	Not Applicable
Target 3. Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths**	3.1	Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission [National Target: 85% by 2009]	88.2% - 410/465 : (2013, Spectrum and PMTCT Programme Monitoring) 87.8% - 391/445 : (2012, PMTCT Programme Monitoring) 49.9% - 284/569; (2011, Spectrum and PMTCT Programme Monitoring) 86.3% (Dec 2010 – PMTCT Programme Monitoring) 86.3% (Dec 2010 – PMTCT Programme Monitoring) 83% (Dec. 2009 – PMTCT Programme Monitoring) 85% (Jun. 2007 – PMTCT Programme Monitoring) 85% (2006 – PMTCT Programme Monitoring) 65% (2005 – PMTCT Programme Monitoring) 47% (2004 – PMTCT Programme Monitoring)

TARGETS	INDICATORS		PERFORMANCE
	3.1a	Percentage of women living with HIV receiving antiretroviral medicines for themselves or their infants during breastfeeding.	Not Applicable
	3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	61.7% (287/456: 2013 Spectrum/NPLH Lab Data) 87.1% (2011, PMTCT Programme Monitoring/ NPHL Lab Data) 58.5% (283/484: 2011, Spectrum/ NPHL Lab Data)
	3.3	Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months.	4.3% : 20 new infections (2013); 465 women needing PMTCT Spectrum Model 11 infections (2013) Programme data from JaPPAAIDS/MOH 3.03% : 12 new infections (2012); 396 women needing PMTCT Spectrum Model 8 infections (2012) Programme data from JaPPAAIDS/MoH 37 new infections(2011); 484 Women needing pMTCT Spectrum Model 20 cases or 0.35 (per 1000) (2010 – pMTCT programme monitoring) 14 cases or 0.25 (2009 – pMTCT programme monitoring) 18 cases or 0.32 (2008 – programme monitoring)
Target 4.	4.1	Percentage of adults and	27.4% (8287/30265 -December 2013. Denominator – all persons living with HIV)

TARGETS	INDICATORS		PERFORMANCE
Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015.		children currently receiving antiretroviral therapy* [National Target: 8,008 Adults, 486 Children by 2012 or 75%. It is estimated that there are 14,000 Jamaicans living with advanced HIV in 2009 – Spectrum/EPP software]	49.4% (8287/16766 from December 2013 – National eligibility guidelines 58.06% (9162/15779 January 2012) 61% (Nov. 2007 – ARV Programme Monitoring) 53% (2006 – ARV Programme Monitoring) 50% (2005 – ARV Programme Monitoring)
	4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy [National Target: 85% by 2009]	89.5% (2013, ARV Database; For persons initiating Jan – Dec 2012) 75.6% (2012, ARV Database – for persons initiating 2011) 91% (2009, ARV database and chart review). 2009 data collected at 5/19 sites, which include sites representative of urban/ rural and large/ small populations 87.6% (2007, ARV database) 75% (2000, ARV Programme monitoring)
Target 5. Reduce tuberculosis deaths in people living with HIV by 50 % by 2015	5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	14/40; 35% (WHO Estimate) There were 14 HIV positive incident TB cases detected through TB surveillance system in 2013 (2013 National TB Programme) There were 32 HIV-positive incident TB cases in 2010. 10 were placed on treatment based on National eligibility criteria (2011 National TB

<table>
<tr><th>TARGETS</th><th>INDICATORS</th><th></th><th>PERFORMANCE</th></tr>
<tr><td></td><td></td><td></td><td>Programme)

64% received co-trimoxazole; 72% received ART (2006 National TB Programme Records)

There were 25 HIV-positive incident TB cases in 2006, and it appears that all who met criteria for ARV received such treatment.</td></tr>
<tr><td>Target 6. Close the global AIDS resource gap by2015 and reach annual global investment of US$22 – 24 billion in low- and middle-income countries</td><td>6.1</td><td>Domestic and international AIDS spending by categories and financing sources</td><td>NASA not available for 2012/2013

Completed (2012, NASA)

<table><tr><th>HIV & AIDS Expenditure by Financial Source</th><th>JMD 2009/10</th><th>JMD 2010/11</th></tr><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></td></tr>
<tr><td>Target 7. Eliminating gender inequalities</td><td>7.1</td><td>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</td><td>9.89% (2012, KABP survey)

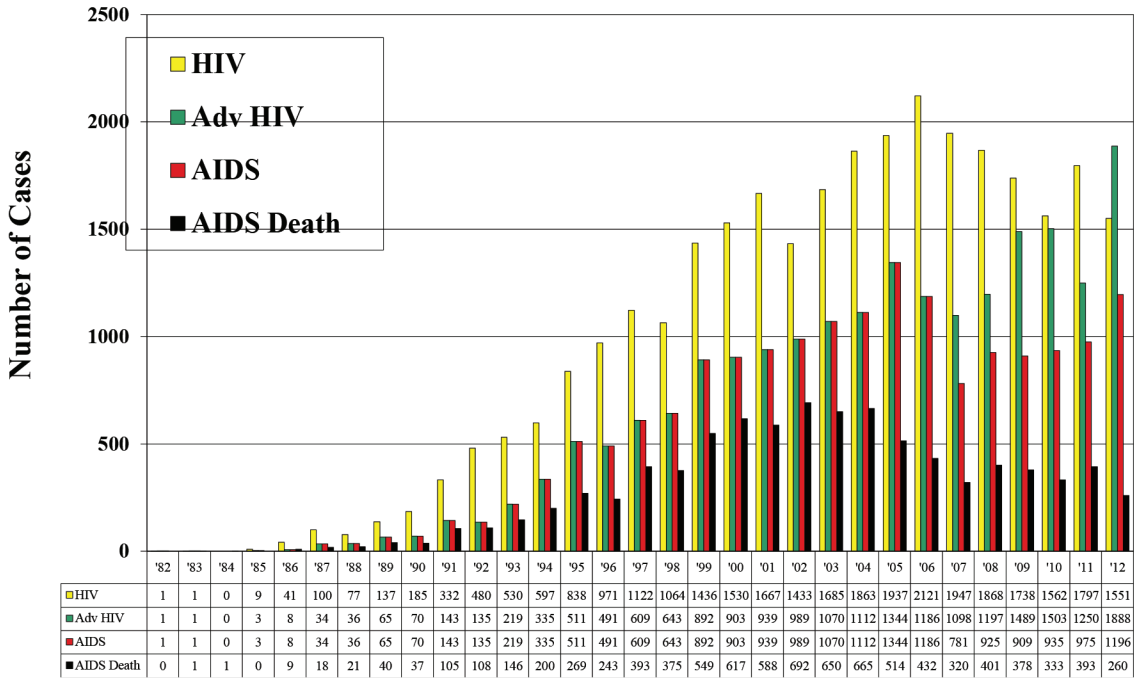
6.5% Physical violence (2008 RHS)
2.8% Sexual Violence (2008 RHS)</td></tr>
</table>

TARGETS	INDICATORS		PERFORMANCE
Target 8. Eliminating stigma and discrimination	8.1	Discriminatory attitudes towards people living with HIV	Proportion of men and women 15 – 49 willing to buy vegetables from a vendor they knew was HIV+ Overall: 28.9% Men: 27% Women: 30.6% (2012, KABP survey) National Target: Men: 30% Women: 40% by 2017 (for composite indicator measuring 5 areas of accepting attitudes)
Target 9. Eliminate travel restrictions		Not Applicable	Not Applicable
Target 10 Strengthening HIV integration	10.1	Current school attendance among orphans and non-orphans aged 10-14*	Data unavailable (2013) .97Male 1.01 Female .99 Urban; 0.99 rural (2005, MICS) National Target: .9 by 2012
	10.2	Proportion of the poorest households who received external economic support in the last 3 months.	Data unavailable
Policy questions (relevant for all 10 targets)		National Commitments and Policy Instruments (NCPI)	Completed (2013, NCPI); See Annex 2

Table 1: Core Indicators for 2011 Political Declaration on HIV and AIDS, Jamaica Data January 2012 – December 2013

Overview of the AIDS Epidemic

Jamaica has an estimated 30,265 persons living with HIV or 1.8% of the adult population. Approximately 30% of these persons are unaware that they are infected with HIV. Between 1982 and 2012, 30,620 persons were reported with HIV/AIDS in Jamaica and the cumulative number of reported AIDS deaths was 8,102 (figure 2).



	'82	'83	'84	'85	'86	'87	'88	'89	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	'09	'10	'11	'12
HIV	1	1	0	9	41	100	77	137	185	332	480	530	597	838	971	1122	1064	1436	1530	1667	1433	1685	1863	1937	2121	1947	1868	1738	1562	1797	1551
Adv HIV	1	1	0	3	8	34	36	65	70	143	135	219	335	511	491	609	643	892	903	939	989	1070	1112	1344	1186	1098	1197	1489	1503	1250	1888
AIDS	1	1	0	3	8	34	36	65	70	143	135	219	335	511	491	609	643	892	903	939	989	1070	1112	1344	1186	781	925	909	935	975	1196
AIDS Death	0	1	1	0	9	18	21	40	37	105	108	146	200	269	243	393	375	549	617	588	692	650	665	514	432	320	401	378	333	393	260

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

Modes of Transmission

New HIV infections in Jamaica have declined by 25% in the past decade, however approximately 2,500 new HIV infections were expected to occur in 2012 (Modes of Transmission Analysis, 2012). Of these new infections, approximately 32% were expected among MSM, making MSM the group at highest risk of HIV infection. Female partners to MSM are also at significant risk with an estimated 7% of new infections. Female sex workers, their clients and the partners of sex worker clients were expected to contribute approximately 11% of incident infections. The general population (i.e. non-key population) engaging in casual heterosexual intercourse was expected to contribute 22% of new HIV infections (figure 3). Mother-to-child transmission of HIV was estimated at 1.9% in 2012, a percent that reflects a trajectory of continuous improvement since the pMTCT programme was established in 2002, and was not a significant contribution to the epidemic.

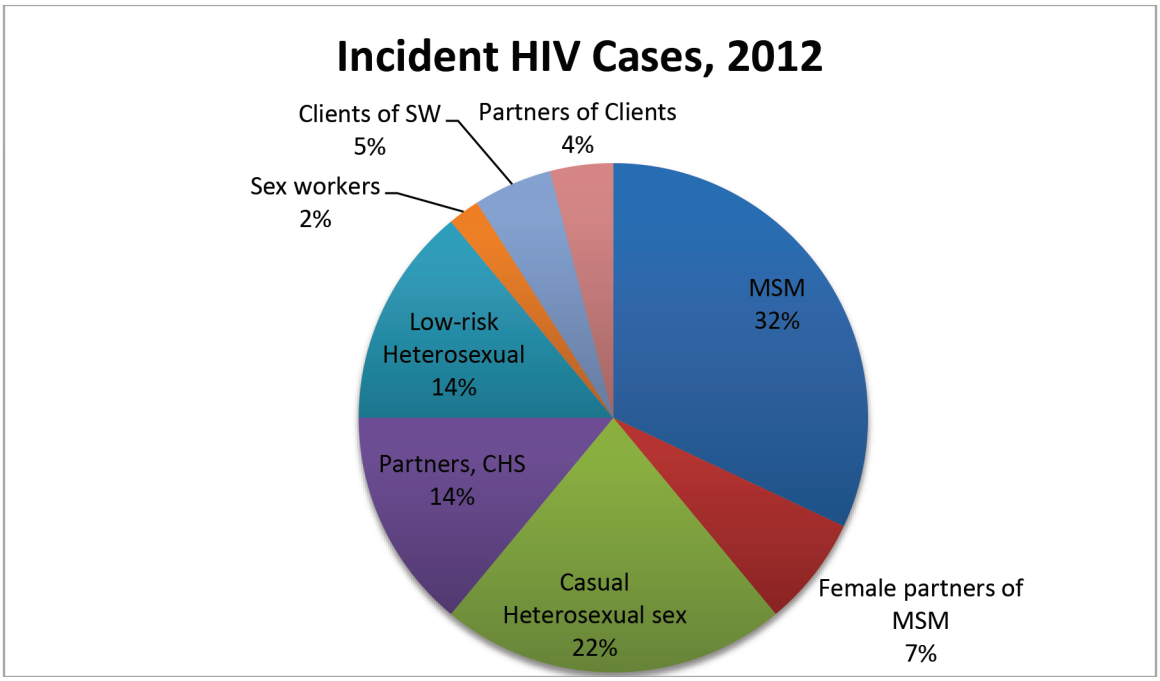


Figure 3: Estimated distribution of incident HIV cases in 2012

Blood transfusion and occupational exposure risk groups are not significant modes of transmission in the Jamaica HIV epidemic. Jamaica maintains full screening of all blood products and universal precautions are widely practiced in the health system. Injecting drug use, although not a significant mode of transmission, was reported in an increasing number of cases between 2008 and 2012. During this 5-year period, 73 reported cases of HIV/AIDS identified IV drug use as a risk factor, which represents 43% of the total number reporting IV-drug use since 1982. The increase is linked to expanded programme coverage among homeless drug users and increased numbers of forcibly returned migrants from North America and Europe; as well it could indicate an emerging shift in the cultural barriers that have long prohibited injecting practices in Jamaica.

Over 90% of persons reported with AIDS have identified sexual transmission, with heterosexual transmission being most commonly reported. However a significant gap exists in the reporting of sexual behaviour among male cases. The sexual practices of 41% of men reported with AIDS and 44% of men reported with HIV are unknown. This may reflect under-reporting by MSM who are unwilling to reveal their sexual practices or reluctance on the part of health care workers to probe sexual practices in interviews. Of the total number of men reported with HIV, 4% identified bisexual and 3.6% identified homosexual sexual practices.

Among reported HIV cases on whom risk data are available, the main risk factors are multiple sex partners, history of STIs, crack/cocaine use, and sex with sex workers

HIV, Age and Gender

Approximately 74% of all reported AIDS cases in Jamaica occur in the 20-49 year old age group, and 86% of all reported AIDS cases between age 20 and 60 years. Total AIDS case rate among men continue to exceed AIDS case rate among women, though this gap has narrowed over the years. Women accounted for 37% of persons reported with AIDS prior to 1995 compared to 44% of persons reported with AIDS between 2004 and 2008 (Duncan et al, 2010) and 46% of persons reported between 2009 and 2012. The growing number of reported HIV and AIDS cases among women may be attributable to exposure through their MSM or other high risk male partners, as opposed to an epidemic now spreading independently in the general population (MOT, 2012).

There is variation in the gender distribution of reported AIDS cases across the lifespan that give important clues to possible transmission dynamics and risk based on age and gender. Females account for the majority of cases in the 10 – 29 years age groups, and among the 15 - 19 year age group, four times as many young women have been reported with AIDS than young men. However, adult males account for a larger proportion (61%) of the cases reported in the 30 to 79 age group.

ANC Sentinel Surveillance

Sentinel surveillance at 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 aged 15 – 24, peaking at 1.96% in 1996 (Figure 4). Between 1997 and 2005, HIV prevalence among young ANC attendees was relatively stable at around 1.5% with a decline to 1% starting in 2007. In 2010, 2011 and 2012, sentinel surveillance of ANC clients yielded HIV prevalence below 1% each year. HIV prevalence among ANC attendees, age 15-24, was 0.67% in 2012.

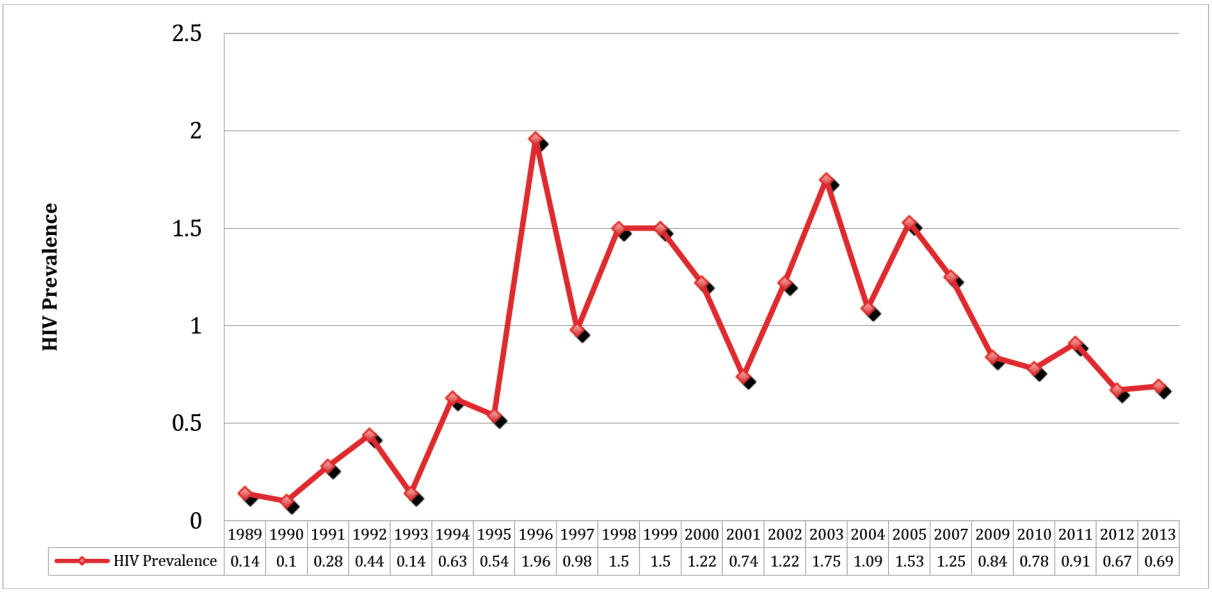
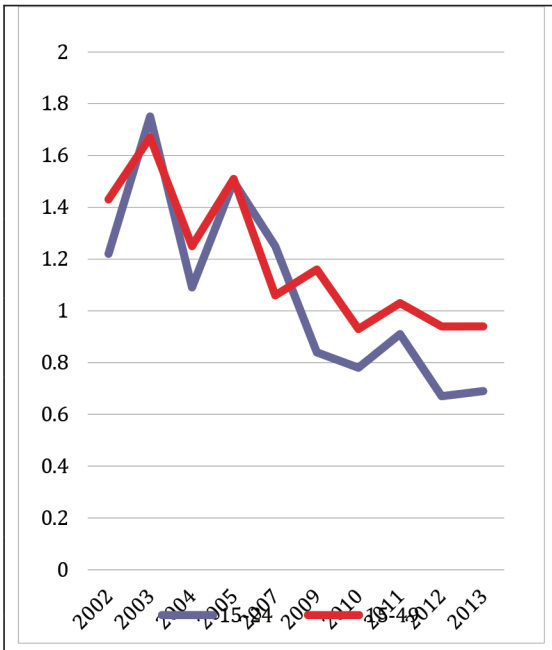


Figure 4: HIV prevalence among public antenatal clinic attendees (15-24) in Jamaica, 1989-2012

The observed decline in HIV prevalence in sentinel sites suggests successful HIV prevention in the general population. The HIV rate in the youngest age group, compares favourably to the total population of ANC attendees aged 15-49. In 2012 and 2013, for every one thousand pregnant women aged 15-49 attending public antenatal clinics, an estimated 9 were HIV infected compared to almost 7 in every 1000 among young women 15-24. Whereas changes in the prevalence in older clinic attendees may be influenced by various sources of bias (e.g. known cases not being re-tested or reported in surveillance logs, known cases avoiding antenatal care due to fear of being judged, decreased fertility in women who are aware of their status, etc) women in the youngest age group are more likely to be newly infected and newly diagnosed. As such, HIV incidence in the youngest group of women may be used as a proxy for prevalence as well as an indicator of incidence in the population.



	2002	2003	2004	2005	2007	2009	2010	2011	2012	2013
15 to 19	0.73	1.3	1.19	1.48	0.83	0.75	0.86	0.88	0.43	0.61
20 to 24	1.68	2.11	0.99	1.58	1.61	0.93	0.72	0.94	0.86	0.75
25 to 29	2.43	1.86	1.9	1.27	1.03	1.58	1.27	1.25	1.26	1.12
30 to 34	1.32	1.49	1.11	2.03	0.37	1.79	0.93	1.04	1.27	1.81
35 to 39	0.94	0.7	0.81	1.12	1.26	0.93	1.11	1.29	1.31	0.73
40 to 44	0	2.86	1.75	1.42	0	2.38	0.87	0.95	1.89	1.32
45 to 49	0	0	0	0	0	0	0	0	0	0.00
Total	**1.43**	**1.67**	**1.25**	**1.51**	**1.06**	**1.16**	**0.93**	**1.03**	**0.94**	**0.94**

Figure 5: HIV Prevalence among 15-24 years ANC attendees and all attendees, 15-49 years, 2002-2012

Concentrated Epidemic

The available epidemiological data support the characterization of the Jamaican epidemic as a low-level generalized as well as a concentrated epidemic during 2012-2013. While remaining at around 1% in ANC sites, HIV prevalence is elevated among key risk groups. The HIV prevalence among MSM, CSW, Inmates and the homeless/drug users is presented in Table 2.

HIV Prevalence	2010/2011	2012/2013
Adults 15-49 years	1.7%	1.7%
ANC attendees (15-24)	0.93% (2010) 0.90% (2011)	0.67% (2012) 0.69% (2013)
STI clinic attendees (15 -49)	2.8% (2010)	2.65% (2012) 2.37% (2013)
Female sex workers	4.9% (2008) 4.2% (2011)	Data available 2014/2015
Men who have sex with men	32% (2011)	Data available 2014/2015
Inmates	2.23% (2010) 2.46% (2011)	2.5% (2012) 1.9% (2013)
Homeless persons/Drug users	12.0% (2010) 8.17% (2011)	2.25% (2012 4.02% (2013)

Table 2: Prevalence by key risk group

Survey data suggest that HIV prevalence is declining among female sex workers (Figure 6). Jamaican female 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 areas. The decline in HIV prevalence among Jamaican sex workers (SW) is credited to decades of sustained interventions with this population.

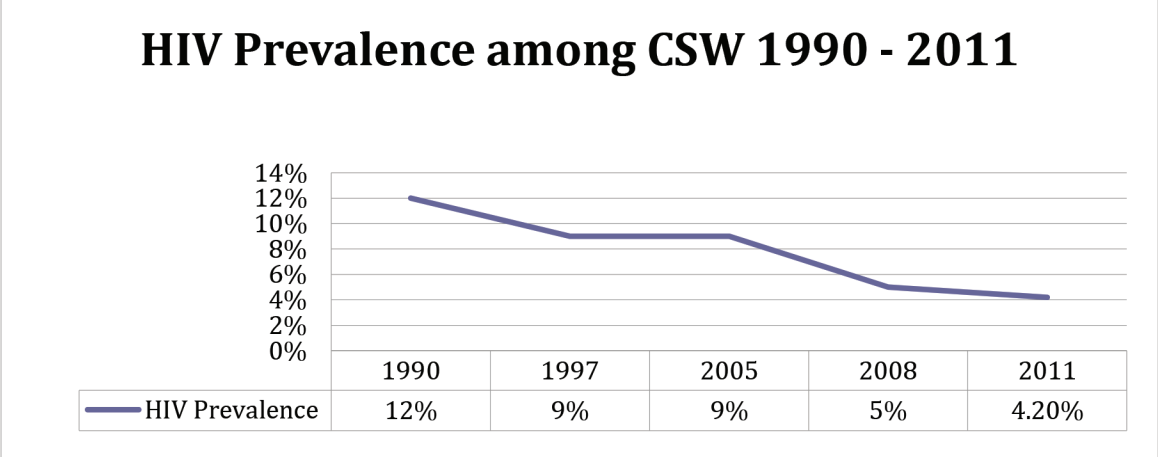


Figure 6: Declining HIV Prevalence among CSW, 1990-2011

Efforts to replicate the level of success achieved with sex workers among MSM have not been successful. National bio-behavioural surveillance of MSM completed in 2008 and 2012 both report approximately 32% HIV prevalence. This high rate is partly due to non-random samples in both surveys. For example, it has been suggested that high levels of risk behaviour, poverty, sex work and incarceration reported in the survey, indicate that high risk, vulnerable MSM are over-represented in the studies. For example, among the respondents, 36.4% report transactional sex and 28.3 % sex report commercial sex. 40.8% of respondents who reported engaging in commercial sex were HIV positive, compared to 28.6% of respondents who reported transactional sex, and 27.6% of respondents who reported no commercial or transactional sex. Some of the correlates of HIV risk identified were: victim of physical violence, history of incarceration, homelessness, rape, and low socio-economic status (Figueroa et al., Unpublished data).

National Response to the HIV Epidemic

A 2013 Caribbean Public Health Agency (CARPHA) led evaluation of the national strategic plan concluded that the "national response to HIV and AIDS in Jamaica under the leadership of the NHP has made tremendous progress in a relatively short period of time. A large number of activities were undertaken in pursuit of the strategies outlined in the NSP, incorporating a wide variety of stakeholders representing many sectors" (Page 97). Despite Jamaica's success in addressing the epidemic, HIV still has the potential to significantly impede the social and economic development of the country. The HIV response must balance addressing the growing epidemic among key populations and maintaining the gains made in the general population. Future gains will require that the national response continue as multi-sectoral, decentralised, and integrated with broader development goals.

Policy and Legislative Framework for Prevention and Treatment

The national response has benefitted from high-level support from national and sector leaders, who have facilitated the progress of various advocacy and awareness initiatives that endorse policy and legislative proposals in support of the implementation of the HIV response.

Six (6) studies identifying gaps in the national response as it relates to creating an enabling environment that facilitates social inclusion, security and protection were completed in 2012 - 2013. The findings were used to provide recommendations for policy directives for the next reporting period. The six studies completed were: A Situational Analysis of Patient Confidentiality within the Public Health Care Sector; A Review of the National HIV-related Discrimination Reporting and Redress System (NHDRRS); HIV/AIDS Legal Assessment of Jamaica; People Living with HIV Stigma Index Survey; Desk Review of existing Ministry of Labour and Social Security Policies and Systems including the Overseas Employment Programme; Situational Analysis of Psychosocial Needs of Orphans and Children made Vulnerable by HIV/AIDS.

The Child Care Protection Act, the National Youth Policy, The National Policy for the Management of HIV and AIDS in School and The Health and Family Life (HFLE) Curriculum were reviewed in this reporting period.

National Family Planning Board – Sexual Health Agency

The importance of linking reproductive health (RH) and HIV/AIDS policies, programmes, and services has been acknowledged by six major international agencies. These linkages are considered essential for meeting international development goals and targets, including the United Nations Millennium Development Goals and the integration of the HIV response and the family planning (FP) programme promotes the achievement of several targets outlined in the 2011 United Nations High Level Meeting Political Declaration on HIV and AIDS. Specifically:

Target 1.	Reduce sexual transmission of HIV by 50% by 2015
Target 3:	Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths.
Target 7:	Eliminate gender inequalities
Target 8:	Eliminate stigma and discrimination
Target 10:	Strengthen HIV integration

HIV and Family Planning integration allows providers to efficiently and comprehensively address clients seeking HIV services and those seeking reproductive health services. In addition, strong linkages help to ensure that the reproductive health needs and aspirations of all people, including people living with HIV, are met. Integrating FP services into HIV prevention treatment, and care services provides an opportunity to increase access to contraception among clients of HIV services who do not want to become pregnant, or to ensure a safe and healthy pregnancy and birth for those who wish to have a child. Integrating HIV services into the existing FP infrastructure is an opportunity to expand HIV prevention efforts and increase the use of care and treatment services. In both approaches, integration has the potential to draw on the strengths and resources of both programmes in order to increase access to prevention, treatment and FP services, improve sexual health outcomes, and contribute to HIV and family planning goals.

Cabinet approved the integration in March 2012, allowing for the integration of the Prevention, Enabling Environment & Human Rights, and Monitoring & Evaluation components into the National Family Planning Board to create the National Family Planning Board – Sexual Health Agency (NFPB-SHA).

Public Health Order

Cabinet approved the proposed Amendment to the Public Health Order to have HIV classified as a Class 1 notifiable disease for reporting purposes in 2012. With this approval HIV is therefore not subject to other Acts and Regulations which have no relevance in view of the modes of transmission of HIV. This Amendment further secured the removal of legislative barriers for persons living with HIV to access education and employment in the education and tourism sectors and the food industry.

The passage of this amendment gives legislative support to interventions in the food industry, an area with particular cultural sensitivities and stigmatising attitudes towards persons living with HIV as reported in the 2012 HIV/AIDS Knowledge Attitudes and Behaviour Survey. On December 1, 2011 the Ministry of Labour and Social Security (MLSS) launched its Food Proclamation Project to directly address discriminatory practices within the industry towards HIV and persons with HIV/AIDS. In 2012 and 2013 the MLSS implemented a pilot project targeting 8 food manufacturers with the aim of having them develop proclamations to reduce HIV related stigma and discrimination. To date, four of the eight companies have drafted proclamations.

Figure 7: Logo for Jamaica's Justice for All Programme of activities

Justice for All

The newly integrated National Family Planning Board – Sexual Health Agency (NFPB-SHA) led Jamaica's arm of the Pan Caribbean Partnership against HIV and AIDS (PANCAP) Justice for All initiative. Jamaica's involvement in the Justice for All Programme is an example of the Government's commitment to tackling Stigma and Discrimination (S&D). Initiated in 2013 by Professor John Edward Greene (UN Secretary General Special Envoy on HIV and AIDS in the Caribbean), the programme aims to achieve one of the goals of the 2011 United Nations High Level Meeting Political Declaration on HIV and AIDS that is to eliminate S&D against people living with HIV by 2015 and to uphold human rights and dignity of all.

The programme involves a series of cluster consultations with youth, civil society, faith-based organisations, private sector and parliamentarians. The main areas for discussion, consensus and strategies are:

- Enhancing the family spirit in the form of national and regional solidarity to support and care for those in need
- Increasing access to treatment including affordable medicines
- Reducing gender inequality including violence against women, girls and children
- Promoting sexual and reproductive health and rights in the context of self-worth
- Achieving legislative reforms for modifying and repealing punitive laws that infringe human rights

In December 2013, World AIDS Day church service was hosted by the United Theological College of the West Indies under the "Justice for All" theme and the first consultation with parliamentarians was held. The Ministers of Health and Justice, Hon Dr. Fenton Ferguson, and Senator the Hon. Mark Golding led this consultation. Parliamentarians from both the ruling party and the opposition were present. One common agreement was that some *antiquated* laws that negatively affect the HIV response should be reviewed. They also requested that cluster consultations be continued in 2014.

Figure 8: Parliamentarian cluster consultation, Justice for All Programme

Workplace Policy

In 2012 – 2013 several key milestones are noteworthy on the path to giving legislative effect to the National Workplace Policy on HIV and AIDS which was first accepted by Parliament as a Green Paper in 2010. In 2012, The National Workplace Policy on HIV and AIDS was further revised based on ILO Recommendation 200 and recommendations from the Attorney General of Jamaica. The Revision was resubmitted to the Human Resources Committee of the Cabinet in July 2012 and approved as a White Paper by both Houses of the Parliament in February 2013.

A new draft Occupational, Safety and Health (OSH) Act was presented to the Legal Department of the Ministry of Labour and Social Security (MLSS) to include a definition of HIV-related discrimination, which will be deemed criminal under the Act. The Minister of Labour has placed the Act as priority for submission to parliament for debate. Additionally, HIV Regulations have been drafted. The HIV Regulations, which are expected to accompany the pending OSH Act, will give legislative effect to the National Workplace Policy on HIV and AIDS, which requires private and public sector entities to adopt or adapt and implement policies within the workplace to address issues related to HIV and AIDS. The Regulations will also outline sanctions for breaching the tenets of the Policy.

Jamaica, through MLSS in collaboration with the Jamaica Employers Federation (JEF), and the Jamaica Confederation of Trade Unions (JCTU), is one of 16 countries to implement the ILO HIV/AIDS Workplace Education Programme. The Voluntary Compliance Programme (VCP) is one of the initiatives designed and implemented by the MLSS to work with private sector companies to ensure voluntary compliance based on the expected requirements of the pending OSH Act and HIV Regulations.

The Ministry of Justice (MOJ), Ministry of Industry Investment and Commerce (MIIC), Ministry of Science, Technology, Energy and Mining (MSTEM) and Ministry of National Security developed and approved Workplace Policies on HIV and AIDS that were launched in December 2012. The Ministry of Foreign Affairs and Foreign Trade (MFAFT) re-launched their policy in 2012 subsequent to significant updates after the first launch. With these additions, all government ministries and agencies have developed Workplace Policies on HIV and AIDS.

Figure 9. Launch of the National Workplace Policy on HIV and AIDS – White Paper and the OSH Profile of Jamaica (December 2013) featuring members of Parliament & Government, Union Representatives, Private Sector Representatives, International Funders and the Network of PLHIV.

Private Sector commitment

The private sector forms a part of the Tripartite approach to addressing HIV in the Workplace with representation from the Jamaica Employers' Federation (JEF). This is exemplified not only in their participation in finalizing the White Paper but also in their commitment to also adopt workplace policies on HIV and AIDS and to participate in Jamaica's national response to HIV. The JEF currently chairs the Jamaica Country Coordinating Mechanism. Leading up to 2013, over 220 large private sector companies were reached through the HIV Workplace Programme; of that number more than 160 had developed workplace policies and/or action plans. 48 small to medium size companies have been reached, all with draft policies and action plans. A total of 268 companies have enrolled in the Voluntary Compliance Programme.

Mobilizing financial support in the private sector is essential to the sustainability of the national response and to achieving Target 6: close the global AIDS resource gap by 2015 and reach annual global investment of US$22–24 billion in low and Middle-Income Countries.

The JaBCHA National Foundation (a private-public sector partnership) is expected to take the lead in mobilizing resources to support the national response to HIV/AIDS. In 2012 the Foundation raised J$6 Million from local corporate contributions. In 2013, a new Board of Directors and Trustees was nominated and approved that has a key mandate to oversee the rebranding of the Foundation. While HIV remains the main priority, the foundation has expanded its focus to include four (4) non-communicable diseases – Cardiovascular Disease, Cancer, Diabetes, and Respiratory Disease.

Access for minors

The Adolescent Health Unit of the Ministry of Health, with the support of a multi-sectoral Adolescent Policy Working Group has led the process of reviewing policies that limit adolescent access to Sexual and Reproductive Health Services. To date, this has included the implementation of a legal analysis in 2012 and a series of island-wide public consultations in 2013. This process has garnered broad political support as demonstrated through the formation of an Inter-ministerial Committee, led by the Ministry of Youth. A concept paper was developed and finalized with input from four government ministries and other high-level leaders. The concept paper will form the basis of discussions on proposed legal changes in the parliament.

Greater Involvement of Persons With HIV/AIDS (GIPA)

The GIPA Capacity Building Programme is designed to further strengthen the PLHIV community's actualisation of their greater involvement based on the international principle. GIPA's role in the HIV response has evolved in response to changing needs of stakeholders and funding priorities. During the reporting period, the Greater Involvement of Persons with HIV/AIDS (GIPA) was facilitated through the GIPA Coordinator and the GIPA Facilitator under the purview of the Enabling Environment and Human Rights Unit. Through a collaborative agreement in July 2013 between the Jamaican Network of Seropositives (JN+) and the Director, Enabling Environment and Human Rights, the GIPA Unit became the capacity building arm of JN+.

In 2012 -2013, the GIPA Capacity Building Programme served to further strengthen self-determination and the PLHIV community's actualisation by training leaders to advocate and educate communities to reduce HIV-related stigma and discrimination, including gender-based violence. Each cohort in this programme participate as a leadership group that commits to a series of trainings over a 6-month to one year period to build in-depth knowledge about HIV; unpack root causes of stigma, discrimination and gender-based violence; and grow skills and confidence to be able to strengthen their leadership in the spaces where they are active - ranging from peer support groups, to workplaces with HIV education programs, to community faith-based organizations, to decision-making bodies such as the Global Fund for AIDS, TB and Malaria Country Coordinating Mechanism. As

part of the process, PLHIV leaders also benefit from the unique opportunity for ongoing exchange of experiences and building of linkages among a diverse range of PLHIV leaders across the island, with the specific focus on enhancing their roles *as leaders.*'

The Jamaican Offences Against the Persons Act

The Jamaican Offences Against the Persons Act (Sections 76, 77 & 79) (also referred to as the "buggery" law) prohibits anal sex between men, men and women, or man and beast in public or private and is punishable by 10 years in prison with hard labour. The law also refers to male same-sex intimacy as "gross indecency". The acts of which are not defined is a misdemeanour punishable by 2 years in prison.

The "Buggery law" limits the ability to provide comprehensive quality services to the MSM population due to fear of criminal punishment as a consequence of disclosure. Due to the criminalization of anal sex, health care providers face specific challenges in providing quality care and services thereby increasing vulnerability of MSM. As well, the criminalization of anal sex among men has impacted the health seeking behaviour of MSM. Removal of the law will facilitate the development and implementation of comprehensive treatment and prevention programmes targeting the MSM population. It is agreed that the repeal of the law will not reduce risk however it will support the implementation of comprehensive programmes targeting the MSM group.

Despite these challenges, the national response has managed to maintain a consistent response among MSM during the reporting period. The legal and policy framework that is adhered to by state and non-state actors alike prescribes to equitable and humane treatment of all persons as set out in Jamaica's Constitution. The Charter of Fundamental Rights and Freedoms (Chapter 3), section 13(3)(h) of the Constitution states that the individual has the right to equitable and humane treatment by any public authority in the exercise of any function and also a right to protection of privacy of other property and communication". Accordingly an individual's right to the privacy of his property, which could be said to include his medical information, is protected. The Ministry of Health institutional framework is supported by legislations and policies that endorse non-discrimination. However the impact of stigma and discrimination has made it difficult to sustain an enabling environment that facilitates the implementation of a comprehensive treatment and prevention programme targeting the MSM group.

Civil Society's effort to increase advocacy through public education and awareness initiatives around the issues affecting MSM and LGBT's ability to live productive lives without the fear of stigma and discrimination was implemented in a variety of forums. These include: training public health workers to provide HIV services to MSMs; We Are Jamaicans Campaign hosted on YouTube; symposium on homelessness and citizenship; sensitization sessions with key stakeholders and members of the community; sensitivity trainings with media practitioners and the re-launch of the LGBT Speakers Forum. As a

result of these and other initiatives, it has been reported that the community has benefitted from an improved working relationship with the Jamaica Constabulary Force (JFC) and other key stakeholders.

In this reporting period, there have been unprecedented constitutional legal challenges launched by AIDS-Free World, an international advocacy organisation. One case was against Television Jamaica (TVJ), Public Broadcasting Corporation of Jamaica (PBCJ) and CVM-TV for their refusal to air an advertisement promoting acceptance and support of LGBT people. The ruling was in favour of the Television Jamaica (TVJ), Public Broadcasting Corporation (PBCJ) and CVM. There are currently two other legal challenges; (1) petitions before the Inter-American Commission of Human Rights to challenge the anti-buggery law, and (2) domestic constitutional challenge to the anti-buggery law before the Jamaican Supreme Court of Judicature.

Prevention, Knowledge and Behaviour Change

Prevention Strategies

In reviewing the National HIV Strategy 2007-2012, the CARPHA Evaluation Team highlighted several Prevention strategies that appear to be making strong headway. Notable strategies/activities include: the implementation of targeted community-based prevention-focused interventions; the use of a broadly targeted mass media campaign using popular artists to spread key prevention messages; the implementation of empowerment workshops with key populations that take a holistic approach to dealing with their needs; working with correctional facilities to address transmission among inmates; partnering with companies and other government ministries to reach working-aged populations with prevention messages; and, partnering with the Ministry of Education to implement activities targeted at youth.

In 2012-2013 efforts were scaled up to create a comprehensive programme of prevention services that addressed the needs of the key populations. Data from the MOT and the 2012 Knowledge, Attitudes, Behaviour and Practices (KABP) reinforced the need for continued interventions in the general population to avoid any potential reversal in gains made and so, concurrent strategies were implemented to address behaviours in the general population that were highlighted by the 2012 KABP survey.

Figure 10. Volunteers from World AIDS Day 2013 volunteers wearing T-shirts displaying key words for social media campaign

General population

Media Campaigns: The National Response continued several campaigns to sensitize the public on several critical issues related to HIV/AIDS. The continued campaigns included: Smart Women Always Buy Carry and Use Condoms (targeting women and condom use), Adolescent Docudrama (on condom use and HIV testing) and Pinch, Leave an Inch and Roll (providing condom use tips).

IEC: Along with the mass media campaigns there was the launch of two new low literacy brochures targeting male adolescents aged 15 -19. The brochures were titled "Condom a Everytime Ting" and "HIV Test: Mek we dweet." The messages conveyed were the importance of condom use and the importance of testing.

Health and Family Life Education: During the period approximately 95% of schools reportedly delivered HFLE. At the beginning of the 2012-2013 school year the revised Grades 7 – 9 HFLE Curriculum was recalled in light of what was deemed 'objectionable content' of the Sexuality and Sexual Health theme, particular content that was directly referenced from an International Planned Parenthood Federation publication on Tolerance and Sexuality. A review committee was appointed to examine the HFLE curriculum and to replace questionable modules, units, topics and activities with content that is culturally sensitive, age appropriate and reflects the standards of the Ministry of Education. However, to prevent any further disruption to the HFLE programme, schools were advised to utilize the original edition of the curriculum (which was not published with the controversial pages) until the current curriculum is reviewed. No new schools were added to the roster of schools delivering the material during this time of review but implementation of the unrevised version of manual was maintained at existing schools.

Dual Method use: With the integration of the HIV Prevention unit into the National Family Planning Board, and the establishment of the Board as the National Sexual Authority, a new campaign focusing on *Dual Method Use* was developed in 2013. The campaign aims to create awareness on the importance of dual protection for STI/HIV prevention as well as unintended pregnancies. The DMU campaign also seeks to empower adolescents and youth to take responsibility and reduce sexual risk taking behaviour. The NFPB-SHA will launch a new campaign in 2014.

Figure 11. "HIV Test: Mek we dweet" brochure

Targeted interventions among Key populations

Through the HIV Prevention Technical Working Group, which was established in April 2010, the National Response continued its partnership with civil society to increase coverage of key populations. The group provides a forum to review, evaluate and assess prevention efforts for Jamaica's key populations in order to identify gaps, build consensus regarding the prevention response and document best practices. During 2012 – 2013 increased funding was provided to NGOs serving key populations to facilitate scale up and continuation of their work. Funded interventions addressed individual sexual and reproductive health and also sought to address structural barriers through social inclusion efforts (providing access to birth certificates and Tax Registration Number), vocational training and income generating grants.

Men who have sex with men

Coverage of the MSM population continues to improve. The results of the 2012 MSM Survey supported the need for increased activities in the MSM population. There has been continued interaction with the MSM community through site visits where routine testing of HIV and syphilis are conducted. MSM are also invited to participate in empowerment workshops where they are sensitized about available educational and employment opportunities.

The Revised MSM Strategy was a major achievement in addressing the high prevalence observed in this population. The Revised MSM Strategy was finalised in 2013 and combines quality biomedical, behavioural and structural interventions, also known as "combination prevention". Strategies include increased use of social media and other technological tools, increased access to condoms and lubricants, increased access to comprehensive treatment care and support for HIV positive MSM, partnerships with social agencies to decrease social vulnerability (including stigma and discrimination), scale up of outreach HIV and syphilis testing, scale up of civil society response.

The HIV response has strengthened its interventions to the population by increasing its network base and maintaining a consistent presence with the target group. These improvements have led to increased access to health services for the population, however the conservative legal and cultural environment has made it difficult to provide/disseminate MSM specific safer sex messages to a wider audience (e.g. men who do not identify, or those who are married or engaged in heterosexual relationships. During the reporting period the national programme funded several sub-recipients to deliver interventions to MSM across the country. Homeless MSM and young MSM were noted as especially vulnerable during this time and during the period there has been an increased effort for reintegration of the homeless with their families. A total of 7,386 contacts were reported and 1,059 HIV tests conducted for the period.

All stakeholders recognised the importance of improving the evidence to guide the interventions among MSM. Even though it is accepted that MSM are a key population at risk for HIV infection, the prevalence estimates are derived from a non-random sample that is susceptible to number of biases. Men from lower socio-economic backgrounds and men involved in sex work may be over-represented in the sample. As well, access to prevention services is likely over-estimated at 86%. Majority of the respondents were recruited through the national programme, NGOs and/or networks of persons being reached through existing programs. Similarly, the reported condom use (75%) is not supported by the high rates of HIV and STI found in the study. The national programme has sought technical support to use respondent–driven sampling methodology to achieve a more representative sample in the 2014/2015 survey.

Sex workers

Interventions for sex workers and their clients addressed their sexual health needs as well as their social welfare. The strategy included frequent site visits, where HIV testing, syphilis testing and pap smears were completed. Persons with positive results were referred to public or private health facilities for treatment. The intervention has facilitated some sex workers in graduating from certificate programmes at HEART Trust (A National Training Agency), while others have benefitted from income generating grants to open up their own small businesses. This is all in an effort to enable SW to leave the sex trade and thus reduce their risk to contracting HIV.

Since the last reporting period the national response has made significant gains in reaching the sub-population of SW who operate from massage parlours and clubs. Guided by lessons learned from the sex work survey, new strategies were implemented and Outreach Officers are able to now interact with these SW and offer HIV-related services. Advocacy implemented by the Sex Workers Association of Jamaica (SWAJ), which conducted interventions with the Jamaica Constabulary Force (JCF) to tackle discrimination served to enhance the response among SW. During this reporting period,

the NHP alongside government and civil society partners who were funded to work with SW reported 21,943 contacts and 2,418 HIV tests among female sex workers across the island.

Homeless Drug Users

The National Council on Drug Abuse (NCDA) continues to target homeless persons and drug users. The NCDA continued its strategy of linking HIV positive substance users to HIV treatment, prevention and care services, and rehabilitation and detox services. Through support from the National HIV Programme, NCDA has increased access to condoms and lubricants, increased access to comprehensive treatment care and support for homeless drug users. An achievement in this area has been the expansion of services to the parish of St. Catherine. For 2012-2013, 788 homeless persons and drug users were tested of which 685 were men and 104 women.

Inmates

The delivery of prevention and VCT services to inmates was institutionalized in 2013 and is now a standard intake procedure within the Department of Correctional Services. There is a designated Reproductive Health Coordinator, funded by the National HIV Programme, with responsibility for providing HIV-related services in the national prisons. With the integration of HIV into these facilities, every inmate that enters the system is offered opt-out screening for HIV and syphilis. Inmates who are found positive are then provided with follow-up care. For 2012 a total of 1,636 inmates (1,403 males and 233 females) were tested and in 2013 an additional 1,916 (1.658 males and 261 females) inmates were tested. The Reproductive Health Coordinator also conducts Men's Health Workshop with the inmates as well as sensitization sessions with the Correction Officers.

The Targeted Community Intervention (TCI)

The TCI strategy, implemented through the Prevention Unit, Regional BCC teams and Civil Society partners, continued with the aim of reaching key populations in communities with high HIV prevalence. The aim of the intervention is to increase community involvement, ownership and empowerment to reduce HIV transmission. Much emphasis has been placed on ensuring that key populations are targeted throughout the intervention.

HIV Outreach Team (H.O.T)

The HIV Outreach Team of the Prevention Unit continued its strategy to meet the increasing demand for scaling up testing services specifically in the South East Region of the Country. With the addition of a new bus and additional driver, H.O.T was able to increase their reach in the reporting period under review. In 2013, HOT provided HIV testing to 19,459 persons (9,811 men and 9,648 women) as well as syphilis testing for 16,034 persons (6,636 men and 9,398 women).

Engaging Faith-based Organisations

The findings from a 2011 FBO-KABP survey informed stigma and discrimination reduction interventions for the sector including the development of training and behaviour change tools, most notable being a docudrama series for faith based leaders and community members. Work with Christian-faith leaders has yielded an increased willingness to engage in conversation around HIV transmission, PLHIV, MSM, SW and other target issues. Through this initiative, FBO leaders have reflected on discrimination in their settings, including the use of stigmatising language used in respect of key populations and have explored opportunities to include HIV in wellness and health discussions within the various auxiliary groups. The challenge remains of engaging other faith groups outside of Christian-faith in the discussion of HIV transmission and issues of discrimination.

Knowledge and Behaviour Change

The main source of data on the impact of prevention efforts on knowledge and behaviour change in Jamaica's population is the national KABP survey. The last study was conducted in 2012 and aspects of the findings were reported in the previous Country Progress Report (2012). As noted previously, the KABP confirms that the epidemic in Jamaica is driven by multiple sexual partnerships, early sexual debut, high levels of transactional sex, commercial sex and inadequate condom use.

With regards to young people's knowledge about HIV prevention, females in all age cohorts performed better than males. For the 15 - 19 age grouping, 38.15% of females gave correct answers to all five questions compared to 33.97% of males. Similarly in the 20-24 age grouping, males underperformed (34.15%) when compared to females (47.50%). Overall the performance for this indicator (38.5%) is concerning given that the MDG target of 95% by 2010 and the national target of 60% by 2011 still has not been met.

Appropriate methods (prompted)	15-24 AGE GROUP		25-49 AGE GROUP	
	YR 2008 (N=893) %	YR 2012 (N=871) %	YR 2008 (N=906) %	YR 2012 (N=929) %
One faithful partner	81.6	73.5	86.3 *	82.9
Condom use all the time	90.9	83.5	90.3	89.7
Abstinence	80.0	81.9	79.7	85.8
Inappropriate methods (prompted)				
Avoid mosquitoes and/or insect bites	27.7	17.3	22.1***	11.5
Not sharing food with PWAIDS	11.5	9.0	9.7	8.8
Not touching someone with AIDS	8.2	2.6	7.6	3.6

*p<0.05;***p<0.001

Table 3: HIV and AIDS specific knowledge by Age Year 2008 VS Year 2012

As illustrated in table 3, the endorsement of individual items was fairly high among persons in the 15-24 age group across the last 2 surveys. The areas that have trended downwards are endorsements of having one faithful partner and 100% condom use. However, the trend for the myths is in a positive direction, suggesting that sensitization efforts are having impact and young persons are now more accepting of having close contact with persons living with HIV. With regard to endorsement of appropriate methods, programme data suggest persons do in fact know that these are the appropriate prevention methods, however they do not believe they are 'fool-proof', and this may lower their endorsement of the methods. For example, among reasons for their perception of their risk of becoming HIV positive, 6.5% of respondents stated, "condoms

can burst; not 100% safe" (KABP, 2012). This included participants who reported using condoms "most of the time".

Reducing multiple partnerships is another key indicator for achieving Target 1. KABP, 2012 data suggested a decline in multiple partnerships across age groups and gender. The data also revealed an increase in frequency of condom use among persons reporting multiple partnerships. Condom use increased for "sometimes" and "most-times" users with a corresponding decrease in those reporting never using a condom. This indicates an improvement in risk perception. However, the overall proportion of users at last intercourse did not improve, and this value decreased among young adults and women over 25, but improved for men over 25. Perception of little or no risk for HIV infection and low condom use intention likely underlie the less than optimal condom use.

The KABP, 2012 also revealed an increase in transactional sexual relationships among the youth. The figure moved from 39.1% in 2008 to 42.6% in 2012. Transactional sex involves the exchange of gifts or money for sex. Only 50% of persons reporting transactional sex also report condom use all or most of the times and 69% of those who do not now use a condom have no intention of changing.

The data suggest youth vulnerability will likely increase without sustained interventions. While the sentinel surveillance data among 15-24 year olds suggest decreased incidence, the KABP survey reveals a number of beliefs, practices and behaviours that indicate persisting vulnerability and the possibility of reversal of gains if prevention efforts are not sustained.

Interventions among adolescents and youth must be prioritised even as Jamaica scales up the response among key population. For this to occur, increase investment in bio-behavioural research among this population (including the 10-14 age group) to inform evidence based response to their SRH needs. The current policy and legislative framework limit the scope of research and intervention among adolescent and youth.

Target 7 – eliminating gender inequality, was measured by assessing physical or sexual violence in intimate partnerships in the past year. Jamaica performed well on this indicator (9.8%), however much work remains to be done to eliminate 'gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV'. While reported Gender-based Violence (GBV) is low in the general population (as measured by UNGASS indicator 7.1) other data show high lifetime prevalence of physical (57.4%) and sexual (23.4%) violence among women with HIV who are seen in public treatment sites (Jarrett, et al., 2012).

Assessed also on the background of higher rates of female unemployment, female job segregation in low paying job sectors, as well as the general under reporting of sexual and

physical violence, it can be assumed the current indicator on intimate partner violence does not represent the magnitude of the problem Jamaica faces as it relates to gender inequality. Gender inequality is a major factor for HIV and to date the country has not been able to adequately assess and/or address this issue, though plans are being put in place to address the issue.

With funding from UNWOMEN the Government of Jamaica through the Office of the Prime Minister is currently finalizing the revised Draft National Strategic Action Plan on Gender-based Violence (NSAP-GBV). The consultations for the revised document involved PLHIV and key population in an effort to ensure that the plan addressed issues surrounding gender and HIV. The Government of Jamaica in 2013 also continued implementation of the National Policy on Gender Equality with one of its key objectives being the reduction of all forms of gendered discrimination and the promotion of greater gender equality and social justice. Also, the National Policy for the Reintegration of School Aged Mothers into the Formal School System was passed in 2013. The Policy allows teenage mothers to return to school so that their education can remain relatively unaffected by the birth of a child. This Policy will lessen their vulnerabilities by ensuring that they are able to still obtain an education.

Treatment

The impact of the treatment program is reflected in surveillance data that documents a decrease in the number of reported AIDS deaths from 665 in 2004 to 260 in 2012. During 2013, 1519 more people living with HIV (PLHIV) accessed antiretroviral (ARV) treatment thereby improving their quality of life. Preliminary data indicates <2% chance of HIV transmission from mother-to-child in 2012 and 2.5% transmission rate in 2013; and by case definition, the Congenital Syphilis rate was maintained below the elimination level during this period. Expansion of the HIV programme has also resulted in increased access to HIV testing, which has contributed to earlier diagnosis of PLHIV and timelier access to ARV. Civil society, private sector and other stakeholders conducted over 497,000 HIV tests in 2012-2013 and almost 50% of men and 68% of women have been tested for HIV and know their result (KABP, 2012). Based on 2013 estimates, only 36% of persons living with HIV are unaware of their HIV status.

Revised guidelines for the management of PLHIV was published in 2013 and disseminated to all treatments sites in 2014.

ARVs & Medical Management

Persons living with HIV received care at 23 public treatment sites island-wide during this period. All public sites are located at facilities that provide other health services, making care for PLHIV available within an integrated service setting. In addition, a total of 75 NHP/MOH certified practitioners offered service to PLHIV in the private sector. Care and support services were enhanced by the addition of four regional psychologists, who provided counselling to over 1,300 persons in 2012-2013.

The NHP/Ministry of Health (MOH) continued to dispense ARVs from the treatment site pharmacies and through the partnership with the DrugServ pharmacies (Public pharmacies) and select private pharmacies. There was one ARV stock out in 2013.

Of the estimated 30,265 PLHIV in Jamaica in 2013, approximately 16,766 were in need of ARV treatment. Since the public access programme to antiretroviral treatment (ART) was introduced in 2004, approximately 1,000 to 1,500 new persons were placed on treatment each year. At the end of 2013, approximately 10,982 persons with HIV were started on ARV treatment. Despite consistently increasing access, the proportion of persons retained on care has been declining. Data show that of those who initiated treatment in 2011, only 74.1% were known to be alive and still on treatment 12 months after initiation. While the level of retention achieved in 2012 is similar to other developing countries, it represents a declining trajectory from 75.6% retention for the cohort initiating treatment in 2010 and 86% for the 2009 cohort. It is important to note that the data collection system poses a limitation in accurately monitoring this indicator (i.e. treatment site databases are not linked across sites), and likely underestimates retention. In response to this challenge, the TCS unit has developed a linkage and retention protocol to strengthen

the retention and linkage process by outlining the roles and responsibilities of treatment site staff, including those involved in outreach testing and laboratory services. Efforts to address retention have yielded some success and the level of retention for the cohort initiating in 2012 is estimated at 89.5%,

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

During the previous reporting period (2010-2011), CD4 testing via the use of PIMA machines was introduced at 3 treatment sites. In 2012-2013, 8 additional machines were introduced to further reduce the reliance on centralized processing and thereby improve access to CD4 testing. During the reporting period, PLHIV accessed 20,976 processed CD4 tests.

Dried Blood Spot (DBS) samples as DNA PCR testing of HIV exposed infants, which was introduced in 2009, is fully implemented at all treatment sites and has resulted in high coverage of early infant diagnosis. During the reporting period, infants born to HIV Positive women accessed 1,491 DNA PCR results. This total includes 87% of HIV exposed infants who received DNA PCR for HIV within 2 months of birth.

	PCR		CD4		VL	
YEAR	2012	2013	2012	2013	2012	2013
Received	793	765	11,276	10,813	9476	10407
Processed	772	719	10,742	10,234	8443	6969
Rejected	45	21	**534**	**423**	513	433
Rejection Rate	**5.6%**	**2.7%**	**4.7%**	**3.9%**	**5.4%**	**4.2%**

Table 4: Number of CD4 and PCR samples received, processed and rejected in 2012-2013

Viral Load testing remains centralized at the NPHL, the only laboratory with this capability. During the reporting period, PLHIV accessed 19883 viral load tests.

Initiative for Elimination of Mother-to-Child Transmission of HIV and Syphilis

The Prevention of Mother-to-Child Transmission (pMTCT) Programme has resulted in provision of ARVs for the majority (88%) of pregnant women and HIV exposed infants (98%) delivered in the public sector in 2012. With regards to syphilis, annual monitoring data suggests that Congenital Syphilis was maintained below the elimination rate. The programme has maintained this level of performance since at least 2006. While monitoring data are not available for the private sector, national surveys (RHS, 2008; KABP, 2008; KABP, 2012) and national surveillance data (paediatric AIDS and paediatric AIDS deaths), suggest that similarly high coverage exists in the private sector. These sources do not support Spectrum estimates of a 30% gap in the ARV coverage of HEI and pregnant women.

	2005	2006	2007	2008	2009	2010	2011	2012
# Antenatal Clinic Attendees Tested	28,651 (96%)	28,446 (95%)	22,478 (95%)	29,119 (>95%)	30,076	26,697	27,985	33,378 (99%)
% HIV-positive women getting ARVs	**74%**	**84%**	**84%**	**83.1%**	**84%**	**87%**	**85%**	**88%**
#/% Infants getting PMTCT interventions	**353 (87%)**	**403 (93%)**	**350 (97%)**	**608 (98%)**	**430 (98%)**	**408 (97%)**	**413 (100%)**	**422 (98%)**
HIV MTCT Rate	**10%**	**<10%**	**<5%**	**<4%**	**2.7%**	**4.6%**	**2.4%**	**1.9%**

Table 5: Prevention of mother to child transmission programme data
Data Sources: Ministry of Health, STATIN and JaPPAAIDS/UWI

A multi-sectoral steering committee comprising government, academia, development partners, and non-governmental organizations, was established in 2012 to provide technical guidance to ensure the pMTCT programme can meet all structural and data requirements for achieving elimination status by 2015. To qualify for elimination status, countries must be certified in the following criteria:

1. Evidence of **achievement of the elimination targets** for at least three (3) consecutive years.
2. Existence of an **adequate surveillance system** capable to **detect all cases** of mother-to-child transmission of HIV and congenital syphilis, and capture service delivery and outcome data from the **public and private sector.**
3. Documented evidence of the essential **programmatic capacity** to sustain the elimination targets and objectives.

Orphans and Children made vulnerable by HIV/AIDS

Generally speaking, the policy and legislative framework for the protection of children in Jamaica does not directly address the issues of children with HIV. In 2012 -2013 there was limited strategic effort around orphans and children made vulnerable by HIV/AIDS. The national treatment programme has significantly reduced AIDS deaths and the pMTCT programme has significantly reduced vertical transmission of HIV, however efforts to address the needs of the aging OVC population have not kept pace. There is a lack of data and understanding of the current situation of OVC and a recently conducted study (World Learning, 2013) presents a dismal picture of their social condition. The study included survey data from 60 OVC age 12 -17 in state and family care, and 30 Caregivers of OVC age 0 through 17. In this study, from the total sample of ninety (n=90) respondents twenty one percent (n=19, 21.1%) said they had frequent absences from school, 27.8% (n=25) said they had occasional absences from school, and 51.1% (n=46) said that did not have frequent absences from school. The main reasons given for absences were: 'No lunch money' 30.3%% (n=23), 'No taxi fare' 23.7% (n=18), and clinic appointments 15.8% (n=12.) In terms of food security and nutritional status, sixty-nine percent (68.9%, n=62) said that they always eat at least two meals per day, 20.0% (n=18) said they sometimes eat two meals a day and 11.1%, (n=10) said that they do not eat two meals per day. One-hundred percent (100.0%, n=20) of children living in state care said that they ate two meals a day, compared to 60.0% (n=42) who lived at home with families (P= < .003). Similarly children in state care were more likely to report always having enough food to eat 80.0% (n=16) compared to children living at home with families 37.1% (n=26 (P=<.003). Government and civil society partners have acknowledged the problem and have made the call for a strong multisectoral response to address the needs of orphans and children made vulnerable by HIV.

Challenges in Treatment

Despite these achievements, the treatment program in Jamaica has identified gaps that must be addressed.

Linkage/Retention in care – Entry into and retention in care are essential components of antiretroviral treatment success. Poorly developed/utilized linkage, retention and referral systems, conflicting work hours and clinic/pharmacy opening hours, stigma & discrimination, distrust in the health care system and financial hardship can all hinder involvement in treatment. The newly developed Linkage and Retention Protocol seeks to provide health care workers (HCW) with guidance that will strengthen the linkage and retention system. The need for additional treatment sites has been noted and the Ministry of Health is actively working to address this through a number of initiatives. One such initiative is being implemented in collaboration with CHAI and seeks to use incentives to increase enrolment at underutilized treatment sites. Creating additional sites will reduce burden at existing sites, reduce travel time, waiting time and associated financial costs. Establishing new sites requires significant effort as it carries financial costs

(i.e. need for increased staff, infrastructure) as well, expanding existing sites is a challenge as physical limitations do not always allow for the addition of new treatment rooms or additional staff.

Adherence – Individual adherence to medication remains a major challenge and negatively impacts the success of the treatment and prevention programmes. Poor sequencing of ARVs by some physicians also needs to be addressed. The revised treatment guidelines take a holistic approach to treatment and highlight not only clinical management but speaks to the importance of psychosocial care for PLHIV. Plans are in place to increase the counselling capacity of Adherence counsellors, and to collaborate with CVC to provide Motivational Interviewing training to treatment and care staff.

Diagnostic Services and Laboratory Capacity - Chronic challenges within HCW capacity in managing HIV disease, the transportation system for delivery of samples and collection of results, non-adherence to laboratory monitoring guidelines along with the equipment malfunction contribute to sub-optimal patient care. The CHART led Jamaica Quality Improvement Collaborative has set targets to increase the capacity of HCWs to effectively manage HIV disease and related conditions. The National Public Health Lab has received support to increase technical proficiency and efficiency.

Stigma and Discrimination – The impact of stigma and discrimination in the health sector prevents many persons from getting tested, accessing regular care and/or disclosing their status to their partners. PLHIV often do not want to receive treatment in their community because of concern that others may learn about their status. Stigma & discrimination is especially harmful to key populations, who have to negotiate different stigmatized identities (sexual orientation or practices, poverty, mental illness, HIV status, etc.).

Human resource gap – There is also a severe shortage of human resources in the field and this may be one of the greatest limitations to programme success. Between 2004 and 2012, over 18,000 PLHIV were linked to care, and almost half of them retained (2 or more visits in 2012). These persons require several medical visits each year, diagnostic tests, pharmacy, nutritional counselling and laboratory services. The healthcare workforce has not increased proportionately. The lack of adequate numbers of Medical Officers of Health to manage the programme in the field as well as the general shortages of doctors, nurses, pharmacists, nutritionists, social workers and counsellors limits the programme's reach. CHAI is supporting the NHP to conduct a Human Resources Analysis to support advocacy for additional human resources.

Sustainability – Treatment care and support is funded primarily by international grants. Antiretroviral drugs, HIV testing supplies, supplies for laboratory monitoring of PLHIV and some categories of human resources (e.g., adherence counsellors, psychologists) are solely grant funded. As funding declines, these critical inputs must be fully costed and the financial support and alternate financial support clearly identified. Government of Jamaica has committed to absorbing costs related to maintaining ARV and Clinical

Management of PLHIV, however, this is in the context of an already overwhelmed and under-resourced health sector.

Impact Alleviation

In 2013, 23 treatment sites provided multidisciplinary care in Jamaica. Treatment and care staff cadre was enhanced with the addition of 4 regional Psychologists who counselled over 1,300 patients in 2012-2013. The Treatment and care staff now consists of, Physicians, Nurses, Adherence Counsellors, Psychologists, Social Workers, PLHIV Liaison Officers, Laboratory Staff, Nutritionists, and Pharmacists, and Positive Prevention Nurses. The care and support available to those who were infected or affected were augmented through the assistance provided by key impact alleviating strategies.

Targeted Community Interventions

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

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

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

Positive Health Dignity and Prevention

The implementation of the PHDP strategy was strengthened in 2012 and 2013. Increased coverage and support to HIV positive persons were achieved primarily through individually focused health education and support, i.e. Peer Support Groups. In addition to addressing psychosocial issues among PLHIV, the strategy also incorporated empowerment opportunities and access to income generating projects for persons most in need. The Enabling Environment & Human Rights and the Prevention Units, with technical and financial support from HPP and USAID, developed manuals to guide the training activities in the GIPA Unit and to strengthen peer led support groups. The support groups were implemented to provide on-going intervention with clients identified as most in need by the treatment team.

Children of Faith

The Children of Faith programme supported persons living with or affected by HIV and AIDS through the provision of income generating projects in chicken rearing, retail clothing, farming and cosmetology. The organization's aim is to improve the lives of children infected with or affected by HIV or AIDS, consequently households that benefit from the programme must include children. In 2013, the organization expanded its reach through a programme targeting sex workers. Through partnerships with organizations such as the Rural Agricultural Development Agency (RADA), Child Development Agency (CDA), HEART Trust/NTA, Registrar General Department, Kiwanis Ocho Rios and the Inland Revenue Department, household heads are provided with the opportunity to improve the standard of living of their family through access to remedial education, skills training, social services and technical expertise in income generating areas.

Summer Camp for children of sex workers

In 2013 a two (2) week-long summer camp was held to benefit 50 children (ages 12-18) of sex workers. Interventions with the sex work population shows that children of sex workers have a greater likelihood of entering into sex work. As such, the main objective of the intervention was to reduce the likelihood that these children would enter sex work. The participants were provided with sexual reproductive health information geared towards addressing some of the specific issues encountered in their social contexts. In addition to developing their social skills, provisions were made to support the children with back to school supplies.

National Commitments and Policy Instrument – Trend Analysis 2003-2013

The trend analysis for the National Commitments and Policy Instrument (NCPI) briefly reviews the strategies, policies and legislative environment and programme implementation in support of the country's HIV response. The trend analysis also comments on agreements and areas of discrepancies between overlapping questions as experienced by civil society and government officials. An analysis of key NCPI data from 2003 to 2013 is captured in Annex 2.

The NCPI questionnaire is divided into two sections. Part A was administered to 20 government officials and Part B was administered to 19 civil society organizations, bilateral agencies and United Nations Organizations. Table 6 details the distribution of responses as per sub-section of each parts of the questionnaire.

Part A =20					**Part B =19**
	NCPI Tool Sub-section	# of Persons Interviewed		NCPI Tool Sub-section	# of Persons Interviewed
I.	**Strategic Plan**	7	I.	Civil Society Involvement	16
II.	**Political Support & Leadership**	17	II.	Political Support & Leadership	14
III.	**Human Rights**	13	III.	Human Rights	14
IV.	**Prevention**	7	IV.	Prevention	10
V.	**Treatment, Care & Support**	7	V.	Treatment, Care & Support	9
VI.	**Monitoring & Evaluation**	3			

Table 6: Number of Person who completed each Sub-section of Part A and B of the NCPI in 2014

The tool uses three scales to rate the questions.

Rating Scale 1 to 10: 1 representing the lowest possible rating and 10 representing the maximum rating.

Rating Scale 1 to 5: 1 representing the lowest possible rating and 5 representing the maximum rating.

Rating Scale 1 to 4: Where a rating of 1 represents strongly disagree, 2 represents disagree, 3 represents agree, 4 represents strongly agree.

The trend analysis is structured into three categories. Category one is Part A – Individual Section, which covers sections that are uniquely covered in Part A (i.e. Strategic Plan and Monitoring and Evaluation). Category two is Part B – Individual Section, which covers the section that is uniquely covered in Part B (i.e. Civil Society Involvement). Category three

is Overlapping Sections, which covers the shared sections in both Parts A and B of the NCPI (i.e. Political Support and Leadership, Human Rights, Prevention and Treatment, Care and Support).

I. Part A – Individual Sections

1) Strategic Plan

Since 2005, the country has maintained a rating of 8 for strategy planning efforts in the HIV and AIDS programmes with a spike in 2009 with a rating of 9. In 2013 the consistent rating of 8 has been maintained. There are high levels of stakeholder involvement in the strategic process including the drafting of the NSP 2012-2017 and this has been highlighted in the summary reports as being inclusive of a diverse range of stakeholders. The drafting of the NSP included a number of repeated consultations, which provided the increased opportunity for stakeholder contributions.

2) Monitoring and Evaluation (M&E)

Civil society and development partners do believe that there are areas within M&E that require strengthening and greater involvement of civil society. Capacity building and technical assistance in using M&E tools within civil society is an area for prioritising. Data dissemination and sharing is seen as an area of weakness as data is not reaching civil society to guide their programming efforts. Civil society has rated M&E (under Civil Society Involvement sub-section) average, a score of 3 out of 5, a consistent rating since 2009.

However, the overall rating of HIV-related monitoring and evaluation (M&E) is only asked of government officials. The trend in the rating of this indicator has observed significant increase from 6 in 2003 to 9 in 2009. There is a plateau in this rating of 8, which is observed in 2011 and 2013.

II. Part B – Individual Sections

3) Civil Society Involvement

The NCPI ratings on civil society involvement in the national HIV response have been constant since 2007. The scale was changed from what was used in 2003 and 2005, which means that comparisons for this indicator are as of 2007. Civil society services in the areas of prevention and care are included in the reports and budget of the national programme have both remained constant in their rating of 4/5 and 3/5 respectively in 2011 and 2013. The rating for including civil society in the national plans has plateau at 4/5 since 2009.

Additionally, the ability of civil society to access financial support has also plateau at 3/5 since 2009. Civil society's ability to access technical assistance experienced a decline in 2011 of 2/5 but gained in rating of 3/5 in 2013, which is consistent with the rating received four years ago in 2009.

The overall rating of efforts to increase civil society participation in 2013 is 9. This indicator is experiencing a steady increase since 2009 and 2011.

III. Overlapping sections

4) Political Support and Leadership

This area received the most agreement of the NCPI sub-section indicators. There is high consensus from both civil society and government officials that the Minister of Health has placed the HIV issue on the agenda of a number of bilateral and multilateral meetings and negotiations. During this reporting period the government assumed responsibility from Global Fund to provide free anti-retroviral medications. Outside of these efforts, civil society maintains that significantly more higher-level political support and attention can be given to the issue of HIV particularly with regards to addressing stigma and discrimination in the wider society.

Government officials are quite satisfied with the level of political support and have given a rating of 8 for 2013. This is an increase over a rating of 7 for both 2009 and 2011 reporting periods.

This sub-section does not include a rating scale as an option in Part B for civil society organizations, bilateral agencies and UN organizations.

5) Human Rights

Both government officials and civil society have highlighted a number of legislative barriers to human rights. They include Offences Against the Person Act (Buggery Law), Sexual Offences Act (Prohibit Prostitution), and The Law Reform (Age of Majority) Act.

Overall, the rating by civil society with regard to laws, regulations and policies protecting human rights for 2013 is 5, consistent with 2011, reflecting an enabling environment with minimal in the current legislative framework addressing HIV in the country.

This sub-section does not include a rating scale as an option in Part A for government officials.

6) Prevention

Interestingly, the government rating for implementation of prevention programme had experienced a steady-increasing trend since 2003 to 2009 with a rating of 6 and 9 respectively. However a decline to 8, which is one rating points was observed in 2011. This rating has remained constant in 2013.

Similarly, a steady-increasing trend was observed for civil society rating for implementation of prevention programme since 2003 to 2009 with a rating of 6 and 8 respectively. However a decline to 6 of two rating points was observed in 2011. An increase to 7 was shown in 2013, similar to the rating eight years ago in 2005.

The rating of policy efforts in support of HIV prevention is only asked of government officials. There is a small fluctuation in rating of 6 and 7 since 2005 to 2011. 2013 shows signs of plateauing at a rating of 7.

7) Treatment, Care and Support

The government rating of the efforts in the implementation of HIV treatment, care, and support programmes has steadily increased from 6 in 2003 to a high of 9 in 2009. This significant increase in 2009 was drastically erased in 2011 when the rating fell back 6, as the rating in 2003, an unprecedented three point decline. The trend in 2013, increased to a rating of 7.

A significant increase of a 6-point rating in 2003 to 9 in 2005 was provided by civil society for efforts in care and treatment of the HIV/AIDS programme. The rating stabilised at 8 in 2007 and 2009 with a slight decrease to 7 in 2011. The rating of 7 is constant in 2013.

There is consensus between government and civil society that there is low awareness and knowledge as to the efforts that are presently underway to meet HIV-related needs of orphans and other vulnerable children.

There was a steady-increasing trend observed by government officials to meet the needs of OVCs moving from a rating of 6 in 2003 to 8 in 2007. Since 2007 there is a steady to significant decline in the ratings from 8 in 2007 to 7 in 2009 and to a low of 5 in 2011. The rating for 2013 is 5, demonstrating a low but consistent effort to serve OVCs.

The observed trend to meet the needs of orphans and other vulnerable children is more drastic for civil society. In 2003 the rating was 5 this significantly increased to 8 in 2005 and was maintained in 2007. However, in 2009 a significant decrease was observed as the rating fell by 3 points to a rating of 5. In 2013 the rating has continued its downward trajectory to a low of 2.

Financing the National Response to HIV

The national HIV response in Jamaica has been primarily financed through a loan agreement with the International Bank for Reconstruction and Development (IBRD/ World Bank), grants from the Global Fund to fight AIDS, Tuberculosis and Malaria (GF) and the United States Agency for International Development President Emergency Plan for AIDS Relief (USAID/PEPFAR) with support from the Government of Jamaica (GOJ). However, Jamaica's reclassification as an upper middle-income country by the World Bank has affected the country's ability to qualify for international aid from some sources, which has implications for the sustainability of various government programmes, including health (PIOJ, 2004). Jamaica is in a position to access further funding from Global Fund, however, as a middle income country, Jamaica is only eligible for funding for programmes targeting only those most at risk thereby limiting the availability of support for other key strategies directed at the general population.

Two key financing arrangements expired during this reporting period: the World Bank No. 7556-JM in October 2012 and Global Fund Round 7 in July 2013. At present Global Fund support continues through the Transitional Funding Model (TFM) for a 2 year period and is limited to key populations. The PEPFAR Caribbean Regional Programme under which Jamaica receives financial support expires in 2015.

The 2009-2010 NASA estimated that expenditure on the national HIV/AIDS response was approximately US$ 18.8 million that equates to 0.14 percent of GDP. Prevention consumed the largest proportion of HIV spending (44.4 percent) followed treatment and care (31.6 percent), policy and administration (23.8 percent) and mitigation (0.2 percent). More than two-thirds of total spending was financed from external sources.

The cumulative cost of implementing the National HIV and AIDS Programme over the period 2013-2016 will be approximately US$ 116.8 million at an average annual outlay of US$ 29.2 million. In essence, HIV spending will increase incrementally each year by an average of 6.8 percent with a corresponding rise in per capita spending from US$ 8.83 in 2012 to US$ 11.47 in 2016.

Prevention will continue to be apportioned the largest share of HIV and AIDS resources and will increase progressively from 44.4 percent in 2011 to 51.9 percent by 2016. In the area of treatment and care, allocation for ARV therapy will increase by 75 percent over the short-term in anticipation of an expanded enrolment of persons with advanced HIV infection. Spending in the broad programmatic area relating to policies, administration, research and monitoring and evaluation will increase only marginally (0.3 percent) between 2013 and 2016.

Way forward

On the background of the country's contracting economy, the global financial crisis and the reduction in external funding, a major concern is the potential loss of gains due to challenges in the wider health system which limits the full integration and expansion of HIV services necessary to achieve and maintain sustainability.

Sustainability of the national response to HIV will depend largely on, and can only be achieved through careful costing of the national strategic plan, documentation of the human resources needs for sustainability of programmes, negotiation with the Ministry of Health and other relevant ministries for absorption of essential posts, negotiation with external donors for additional funds, and increased allocations in the MOH recurrent budget for the HIV/STI programme. Other important strategies include rationalization, integration with primary and secondary health care approaches and government subventions for HIV related NGOs.

Mindful of the changing funding climate the GOJ has taken increasing responsibility to finance the costs of the programme moving forward. This is captured in GOJ recurrent expenditure. GOJ has committed to absorb costs related to maintaining ARV and clinical management of PLHIV as part of the counterpart funding under the TFM due to Upper Middle Income (UMI) status. However, this is in the context of an already overwhelmed and under-resourced health sector and additional IMF restrictions. The Global Fund, recognizing the consequences, invited Jamaica to submit a proposal under the New Funding Model to support treatment costs to ensure that the gains made in treatment were sustained. Nevertheless, this is a notable achievement and illustrates GOJ's commitment to provide support to the national programme. The integration of components of the National HIV/STI Programme (NHP) into the National Family Planning Board (NFPB) to form one statutory agency with responsibility for sexual and reproductive health will support the sustainability of the HIV Prevention and the Enabling Environment and Human Rights components.

Best Practices

Core Indicator for Global AIDS Response Progress Reporting	Target 1 > Reduce sexual transmission of HIV by 50% by 2015 Target 8 > Eliminating stigma and discrimination Target 10 > Strengthening HIV integration
Name of organization	Southern Regional Health Authority
Name of project	Adolescent Living with HIV (ALH) Support Group
Area	Prevention
Timeline	2013-Present (on-going)
Funder	Government of Jamaica/USAID
Beneficiaries	HIV Positive Adolescents
Project objectives	• To create an enabling environment or safe space for ALH to have empowering group discussions. • To establish and sustain peer support among ALH. • To improve their self-esteem and leadership skills. • To enable improved parent/caregiver and ALH relationship. • To improve medication adherence from 25% to 80%.
Outputs and/or outcomes	• One monthly meeting held for all ALH in the Region at the end of each month. • Meetings last for 2-2.5 hours. • Fifteen (15) adolescents are consistently in attendance (9M 6F), ranging between 13-17 years.
Evaluation/Results	With the emotional trauma and behavioural problems that the ALH were exhibiting, the support group meetings have created an environment where many of these challenges were addressed. The following have been observed: • ALH freely discussed and asked pertinent questions about nutrition, sexuality, stigma and discrimination, career choices among others. • ALH look out for each by texting one another and maintaining rapport with each other in and outside of support group settings. • ALH are more assertive and confident about their identity and development. They exhibit improved acceptance and increased sense of self-worth and they have also become more pro-active about the direction of their lives. • Parents/caregivers have reported improved relationships with their children or wards. There are less complaints about behavioural problems; ALH have a

	better understanding of HIV infection, thus their blaming the parents/caregivers for the infection has lessened; and parents/caregivers are better able to have discussion with their child/ward thereby reducing the caregiver's/parent's feeling of guilt and inability to deal with said feelings of guilt. • Since the inception of the support group meetings, there is a 100% adherence by self-report and fewer complaints about the taste of the medication.
Lessons learned	• Creating a safe space for ALH is important for their development. • With the support of the psychologist and the liaison officer, behavioural problems are more easily understood and dealt with. • Complete medication adherence is possible as long as the environment is enabling, supportive, empathetic and realistic. • Peer support is critical for personal and social development among members of the group. • Improved caregiver/parent and child/ward relationship with support from staff enables improved health outcome of ALH. • Participatory-approaches in meetings and at home encourage behaviour changes among the ALH. • Sex education is very critical to the development and knowledge base of members of the group.
Challenges	• The lack of financial support for refreshments, phone calls and transportation can affect attendance and follow-up

Core Indicator for Global AIDS Response Progress Reporting	**Target 3 > Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths** **Target 7 > Eliminate gender inequalities** **Target 8 > Eliminating stigma and discrimination** **Target 10 > Strengthening HIV integration**
Name of organization	Jamaica Youth Advocacy Network (JYAN)
Name of project	International Youth Speak out (iYSO) and Live out Loud Projects (iLOL)
Area	Prevention & Enabling Environment
Timeline	Live out Loud Project (April 2012 – December 2012)
Funder	IYSO Project
Beneficiaries	CVC/COIN (iLOL) and Advocates for Youth (iYSO)

Project objectives	IYSO: • Increase youth participation in sexual and reproductive health rights (SRHR) policy advocacy processes to increase access to SRH services, commodities and information. • Build capacity of young people to mobilize at the grassroots/community levels as peer educators to provide sexual health and risk reduction education, rights as well as provision preventative resources. iLOL: • Increase access of SRHR information to LGBT youth. • Provide psychosocial support and referral mechanisms through iLOL LGBT peer educators.

Outputs and/or outcomes	iYSO
	Increased youth mobilization, participation and influence on law and policies. Examples include:
	
	• Successful involvement and lobbying the Minister of Youth for youth SRHR issues to be reflected in revised National Youth Policy in the context of youth diversity.
	• Successful involvement and lobbying Minister of Health through petitioning to move expeditiously to honour in declarations ratified by the Government of Jamaica around youth SRHR.
	• Working closely and supporting policy makers such as Senator Kamina Johnson-Smith for the reintegration of teen mothers into the formal school system.
	• Advocacy youth council involved in review and/or formulation of several laws/policies (some on-going) including:
	  ○ Child Care and Protection Act (CCPA) and VCCT access to minor policy.
	
	• Youth participating in strategic advocacy activities/fora locally, regionally and internationally to influence policies and laws to meet the SRHR needs of young people. Some of these include:
	  ○ Capital Hill, Washington DC to influence international policies.
	  ○ UNFPA Civil Society Meeting in Panama to contribute to the post 2015 Agenda.

	○ UNICEF International Workshop on Youth and Adolescent in Brazil as a part of the Global Human Rights Forum. • Increased partnership and support with youth led/youth organizations with trainings, mobilization and capacity building initiatives especially around SRHR across the island. • Increased provision of preventive resources such as condoms and water based lubricants. • Provision of life skills, comprehensive sex and sexuality education to young people. iLOL: Outcomes include: • Over 2,000 visits for access to SRHR information from website. • Improved mechanism for referral to SRHR information, psychosocial support and services to LGBT youth. • Policy advocacy factsheets and briefs used as lobbying tools as well as information resource in local, regional and international fora and/or programmes.
Lessons learned	• Youth participation and capacity building is extremely important for meaningful impact in HIV and SRHR response. • Increased and appropriate investments in SRHR through an integrated and cross sector approach are important to effectively respond to HIV and AIDS. • Innovative methods for outreach need to be considered such as ICT to provide connection to SRHR health services especially for vulnera-balised and harder to reach populations.
Challenges	• Harmful laws and policies that continue to prohibit access to SRHR education, services and commodities must be removed as these undermine the holistic HIV response. This continues to be a major barrier and challenge for young people in Jamaica.

Core Indicator for Global AIDS Response Progress Reporting	Target 8 > Eliminating stigma and discrimination
Name of Organization	J-FLAG
Name of Project	Providing HIV Services for Gay, Bisexual & Other Men who Have Sex with Men (MSM)
Area	Enabling Environment
Implementing Partner	National Family Planning Board/National HIV/STI Programme
Timeline	July 2013 – June 2014 (1 year)
Beneficiaries	Sixty (60) public health workers
Funder	VIIV healthcare
Project objectives	• To equip the health care providers with specific skills to provide services for the LGBT community. • To increase comfort level of health care provider to providing services for the LGBT community. • To increase knowledge level of participants about practices, attitudes and behaviours of the LGBT community. • To increase awareness of legislation and how they affect the LGBT access to public health services.
Outputs and/or outcomes	• Sixty (60) public health workers, including doctors, nurses, contact investigators, laboratory technicians, peer educators, and ward assistants from the four regions were trained. • Six (6) persons from the NFPB were also trained. • A ten-module training manual on the provision of services for MSM and issues relating to LGBT people and human rights was developed. Topics include Sexuality, Values and Attitudes, Sexual Health of MSM and Gay Men, Anal Sex, Social Context of MSM and Communication. Role-play was used as a tool to transform and to give practical examples to the content of the modules, which moves the words from information into experience and encourages imagination, applicability and empathy. • Participants serve as referrals for J-FLAG and its partners. • Codes of Conduct/Practices will be printed and mounted in participants' health facilities.

	• Visits to health facilities are included as an activity that monitors participants' application of newly acquired information and skills. • Sensitization sessions will be done at health facilities. • Post training survey to determine changes in attitudes and behaviour is included.
Evaluation results	• A third of the participants (37%) said the workshop inspired them to change their thinking about the LGBT people and 63% felt that they were already tolerant, some at the stage of acceptance while others are working on celebrating and promoting LGBT individuals. • The vast majority of participants felt the workshop was useful to enhance their work and that they were now more exposed to the unique issues faced by LGBT people and would make an effort to use the information learned. • The workshop and its objectives have been given notably positive reviews from the participants thus far.
Lessons learned	• The methodology used in this training, i.e. case studies, games, role plays, group work, were very effective as these methods allowed individuals to reflect and also to honestly present their feelings. • The presence of persons of the LGBT community for the duration of the training as well as the MSM panel presentation allowed participants to discuss their concerns with members of the community in a harmonious non- confrontational manner, which facilitated learning. • The inclusion of a range of persons from the LGBT community i.e. persons from the lower income group and persons from the professional/middle income group plus their willingness to share openly with the participants was also beneficial to the training process. Their inclusion assisted in shifting the stereotypes of the LGBT practices and behaviours. • The decision to include all categories of staff in the training may have contributed to the openness of the discussions and the willingness of participants to engage in the activities since a specific category of staff did not feel that they had been targeted for the special training in this area. • The organization of the training in 2 phases with an opportunity for application between the phases was an effective strategy as majority of the persons were able to apply the skills and information they had learned and were

	also able to gauge the attitudes of their colleagues to providing services to the LGBT community. Participants were therefore able to identify the need for additional work with their colleagues.
Challenges	• The cost of the training was a major challenge as it was done residentially to ensure impact. • Some participants felt forced to participate in this project, as they did not volunteer themselves. This affected the quality of their participation. • The diverse nature of the group lent itself to some challenges as the level of understanding varied among the public health workers. The difference in their work (for example, Medical Doctors as opposed to Records Clerk) also posed challenges.

Core Indicator for Global AIDS Response Progress Reporting	**Target 1 > Reduce sexual transmission of HIV by 50% by 2015** **Target 8 > Eliminating stigma and discrimination** **Target 10 > Strengthening HIV integration**
Name of Organization	Children First Agency
Name of Project	Youth MSM Empowerment Project
Area	Prevention
Timeline	Eight (8) months (Jul 2012 to Feb 2013)
Name of Funder(s)	UNESCO
Beneficiaries	Youth MSM, In-school Youths, Key Stakeholder Groups/Organizations operating in the Kingston Metropolitan Region
Project Objectives	• To strengthen knowledge and skills of our target group (50 MSM aged 17-25 years old) on HIV/AIDS and other STIs. • To build the capacity of 20 key stakeholders to better relate to and interact with MSM, through targeted intervention. • To increase the availability of psychosocial support services for young MSM through advanced peer educators training for 10 MSM.
Outcomes/Outputs	**Objective 1:** To strengthen knowledge and skills of our target group (50 MSM aged 17-25 years old) on HIV/AIDS and other STIs. **Activity 1:** Develop youth friendly drama presentation: • A 20-minute youth friendly presentation was developed in consultation with the Children First Mobile Reproductive Health Information Service – Bashy Bus Peer Educators at the Bashy Bus HQ in Kingston, Jamaica. The presentation sought to utilize the performing arts - particularly drama, poetry and songs - to promote and create an awareness of MSM issues.

This presentation was also informed based on focus group discussions with youth representatives of the MSM population where they highlighted the issues that they have experienced and continue to endure in some instances.

- A series of pilot testing of the presentation was done at 2 secondary schools *(1 rural and 1 urban)* with various youth audiences as well as 2 distinct groupings of MSM during the period July to October 2012. The feedback was very encouraging as the audience related that the messages were quite clear and the issues brought to the fore were "true-to-life". These pilot tests brought to the fore the importance of psychosocial testing and support especially amongst the MSM groupings, as the presentations created the space for them to articulate their issues and question where they can go to get support/assistance.

Activity 2: Empowerment Sessions with MSM:

- For the period July 2012 to October 2012 a series of MSM empowerment sessions were undertaken at the BBK HQ in Kingston. The sessions began with a focus group discussion in order to better understand the issues that impact and affect the MSM community and the issues that this new batch of participants experienced. The main topics covered for the period included, Self Efficacy; Advocacy and Risk Reduction Conversations – specifically condom negotiation, Sensitization to VCT, Advocacy, Sexuality, Basic HIV and AIDS Facts, Stigma and Discrimination HIV and AIDS and STI Transmission and Prevention, Treatment and Care; Additionally, one-on-one sessions have been convened with 66 youth participants as part of the overall development planning process and are held at the end of each batch of trainings.
- Overall, the sessions were very successful and provided the opportunity to dispel myths, provide clarification, discuss issues relating to "anal hygiene", created a space to examine future plans and streamline referral to national vocational training programmes such as HEART TRUST/NTA. Finally these empowerment sessions served as a catalyst in preparing youth for Voluntary Counselling and Testing (VCT) for HIV and STI.

Activity 3: VCCT Test:

- A total of 36 MSM participants accessed the VCCT through Children First Mobile Reproductive Health Unit – The Bashy Bus. Each participant was engaged in Pre and post-test counselling and those who tested positive were referred and subsequently accompanied by a Children First team member to a public health clinic that has responsibility for HIV Treatment and Care.

Objective 2: To build the capacity of 20 key stakeholders to better relate to and interact with MSM, through targeted intervention.

Activity 1: Focus Group Discussions with MSM:

- A series of focus group sessions were undertaken with the 66 youth MSMs who were engaged in the MSM Empowerment Training Sessions for the period July 2012 to October 2012. The Focus Group Discussions served to provide the baseline information, which was required to devise the intervention to make it culturally appropriate while addressing the emerging issues and trends.

Activities 2 & 3: 1 Workshop with MSM & Stakeholders:

- These activities were undertaken over a 2-day period in Kingston with a total of 25 persons comprising of youth MSM, representatives from the Office of the Children's Advocate, Children's Registry, Ministry of Health Comprehensive Clinic, Child Guidance Counselling Clinic, Child Development Agency, Bureau of Women's Affairs (Men's Desk), Council of Voluntary Social Services, Dean of Disciplines and Counsellors from four High Schools and two representatives from the Jamaica Constabulary Force (Police) as well as Out of School Youths.
- The sessions focused on understanding the target population, the existing and emerging trends relating to the population as well as sought to explore workable solutions to the challenges (including stigma and discrimination) faced by the group. The youth participants were very willing to share their experiences and make recommendations to the various organizations on how to best meet their needs. The youngsters were also very excited about the opportunity to learn firsthand about the myriad of services available through the various stakeholders. The stakeholders described the sessions as a very rich learning experiences, which enabled them to better understand the barriers that they sometimes "unknowingly" create in serving the population.

- Overall, there was a high level of commitment from the various stakeholder groups to review the recommendations and to internally explore further training for their staff and to collaborate with Children First on other similar interventions in order to keep current in their quest to meet the needs of this population.

Activity 4: Develop health care providers listing:

- This component comprises of approximately 20 health care providers from the Kingston and St. Andrew Region, which is the location of the project. Based on our on-going partnership with these health care providers, individual contacts have been forged that have strengthened the referral process. This health care provider listing has been distributed to MSM participants on a as needed basis.

Objective 3: To increase the availability of psychosocial support services for young MSM through advanced peer educators training for 10 MSM.

Activity 1: Advanced Peer Education Sessions:

- A total of 17 MSM have participated in the Advanced Peer Education Training with 16 successfully completing the process. They have been offering support to their peers and interestingly they have also been volunteering to assist with the on-going MSM Empowerment Training sessions, which provide the opportunity for them to hone their peer education skills.
- Additionally, they were actively engaged in the recruitment of new participants for training and are in the process of developing an advocacy campaign aimed at reducing stigma and discrimination amongst the target group. The training was however, very integral in the young MSM overall development and has enhanced the young men's self esteem and sense of purpose.

Activity 2: Conduct Pre and Post Assessment:

- Pre and Post assessments among MSM trainees during the period July 2012 to October 2012 revealed participants' knowledge base had increased by over 60%.

Activity 3: Risk Reduction and Self Empowerment Sessions:

	• Risk Reduction and Self-Empowerment sessions were undertaken with the targeted MSM population during the period July 2012 to October 2012 as part of the overall peer education training programme. These sessions provided the opportunity for self assessments, introspection and future planning with respect to risks and the impact it has on their health. Overall there has been reported increase in condom usage among the target group as well as increased discussions with their partners on the issues. **Activity 4:** Mobilization of New MSMs: • The advanced trained peer educators as well as those participating in the MSM Empowerment Sessions were very instrumental in recruiting and mobilizing additional participants for the sessions based on the positive impact the sessions had on their overall well-being.

Lessons Learned	• The youth MSM population is desperately in need of a youth information site where reproductive health information can be shared and referrals made to appropriate service providers.
	• The strategy of advanced peer education training served as a useful catalyst in achieving a multiplier effect in reaching other youth MSM.
	• The civil society and the wider community groups lack information on youth MSM, which has led to misunderstanding and can lead to stigma and discrimination.
	  ○ The stakeholder workshop sessions served as a bridge to close those gaps and provided a greater level of understanding about this key population.
	• Reproductive Health Information cannot be stand-alone, and therefore needs a holistic approach (e.g., food support, hygiene kits, and bus-fare assistance/transportation) especially for those individuals who are most vulnerable.
	• The importance of easy access to condoms and lubricants for the population is integral to an intervention of this nature.
	  ○ Based on partnerships with entities such as the Ministry of Health and the National Family Planning Board-Sexual Health Agency, we were able to secure much needed resources (in-kind) to compliment this area of our project activities
	• Behaviour change is a process and there is a great need for sustained interventions especially for this highly vulnerable group of young people.

Core Indicator for Global AIDS Response Progress Reporting	Target 10 > Strengthening HIV integration
Organization	CHARES Clinic, University Hospital of the West Indies (UHWI)
Name of Project	2013 Pilot Project of Provider-initiated Testing & Counselling (PITC)
Area	Prevention and Treatment, Care and Support
Timeline	July 2013 to October 2013
Name of Funder(s)	Clinton Health Access Initiative (CHAI)
Beneficiaries	• Clients accessing care at the University Hospital of the West Indies (UHWI). • Medical interns and residents; Medical ward staff and nurses; Public Health Nurses and Sisters; Emergency Room residents and CHARES staff.
Project Objectives	• Integrate routine HIV testing into UHWI's operational protocols and policy. • Deliver to multiple levels of staff a theoretical training module on HIV as well as provide training on the practical components such as administering HIV tests. • Coordinate linkages with CHARES for counselling and support of HIV positive patients.
Outcomes/Outputs	• Two (2) staff trainings with thirty five (35) and twenty one (21) participants respectively from all named staff categories. • One Thousand Four Hundred and Eighty Five (1,485) patients captured with One thousand two hundred and three (1,203) participating; one hundred and fifty seven (157) opting out; and one hnudred and twenty five (125) missed.
Evaluation/Results	• There is need for clear hospital policy on routine HIV testing and counselling. • There is also great need for HIV screening and confirmatory kits to stock supplies on all wards. • Development, implementation and management of supply chains for testing commodities.

Lessons Learned	• Training should commence at the pre-service level. • Training material should be made available on-line. • Continuous Intra-Departmental activities should be conducted. • Age appropriate information for out-patient clinics. • Continuous supply of results cards. • Improved support by team leaders to ensure HIV screening is performed on all patients – particularly in-patients. • Strengthen data collection activities. • There needs to be a review of programme approach: Laboratory screening, Emergency Department involvement. • There was an acceptable uptake for testing initiative (81% uptake). • There was accurate testing procedure. • The pilot was cost effective (> 0.6% capture). • There were clear gaps in coverage. • There remained uncertainty surrounding sustainability.

Core Indicator for Global AIDS Response Progress Reporting	**Target 8 > Eliminating stigma and discrimination**
Organization	Panos Caribbean
Name of Project	A Communication initiative to fight discrimination and stigmatization against MSM and to promote gay's men health in Jamaica.
Area	Enabling Environment
Timeline	2011-2014
Name of Funder(s)	World Learning / USAID
Beneficiaries	Men who have sex with men / Journalists
Project Objectives	• Strengthen the capacities of MSM in Jamaica to communicate their concerns through innovative communication methodologies. • Build the capacity of the media to report sensitively on MSM issues, including from the perspectives of MSM. • Promote information sharing between local and international media and policy makers on MSM issues thereby expanding local awareness and enhancing public debate about MSM rights and HIV-related issues in Jamaica and on a global level.

Outcomes/Outputs	• MSM trained to collect oral testimonies of peers in Kingston, Ocho Rios and Montego Bay. • 500 copies of oral testimonies transcribed and published. • Ten (10) Key MSM advocates trained in participatory media techniques. • 30 Media workers trained to produce media stories on MSM and HIV issues. • Improved understanding of MSM and HIV issues among 6 media gatekeepers.
Evaluation/Results	• The oral testimonies highlighted a plethora of issues affecting the MSM community in Jamaica, in particular issues of societal stigma and discrimination and its effect on accessing prevention and care services. • Media personnel trained expressed a general willingness to improve on their reporting practices. • Enhanced capacity of MSM to use innovative communication methodologies for advocacy.

Major Challenges and Remedial Actions

Progress made on key challenges

Major challenges reported in 2012 and their remedial actions are summarized below. Details of their implementation are documented throughout the Country Report.

Challenges	Remedial Actions
Stigma and discrimination continues to be a barrier to access to HIV programmes.	The EEHR Unit engaged a consultant to review confidentiality practices in the health sector. This review identified areas where confidentiality was being breached. The recommendations for strengthening the system were integrated into the 2013-2015 workplan for the HIV Technical Officer for Health and Justice. The findings from the 2011 FBO-KABP informed the development of stigma and discrimination reduction interventions including the development of training and behaviour change tools, most notable being a docudrama series for faith based leaders and community members. The docudrama focuses on mitigating stigma and discrimination in faith based settings to challenge stigmatizing behaviour against Sex Workers, MSM and PLHIV. Themes include the use of stigmatizing language and messages; societal attitudes and norms; and inclusion of persons living with HIV and AIDS. In 2013, J-FLAG in partnership with the NHP conducted regional 3-day Public Health Workers training workshops entitled "Providing services for gay, bisexual and other men who have sex with men (MSM)". Among other things, the training addressed MSM-related health issues, how to counsel about anal sex, stigma and discrimination.
Nearly 50% of PLHIV in Jamaica are not aware of their HIV status.	The proportion of PLHIV not aware of their status decreased to approximately 30% in 2012. Outreach testing increasingly focused on transmission networks and socializing sites with high prevalence. Strategies to increase access to MSM population were also implemented. The Revised MSM Strategy was finalised in 2013 and combines quality biomedical, behavioural and structural interventions,

	also known as "combination prevention". Strategies included scale up of outreach HIV and syphilis testing through partnership with varying civil society agencies, increased use of social media and other technological tools, increased access to condoms and lubricants, partnerships with social agencies to decrease social vulnerability (including stigma and discrimination), and scale up of civil society response. Strategies to reach MSM with outreach testing include increased availability of Oral HIV tests, to increase uptake and improve opportunities for discrete testing.
Many of those who are on treatment do not adhere adequately to ARV medication.	The care and support arm of the treatment, care and support component was strengthened through the hiring of four Regional Psychologists in 2012. Though not sufficient to meet the psychological needs of all PLHIV, the introduction of psychologists into the treatment sites allowed for over 1,300 PLHIV to receive individual, family, couple and group counselling. This institutional support addresses access to mental health services and difficulties in ensuring adequate counselling that affect adherence, to complement peer and social support initiatives. Adherence was further addressed through several CHAI supported initiatives to increase attendance at clinic appointments as part of efforts to improve retention in treatment and care. Treatment site staff received support and case management tools to strengthen linkage and retention among patients.
The supply, distribution and dispensing of ARV drugs in Jamaica during this reporting period.	There has been some alleviation of the problems faced with the supply, distribution and dispensing of ARV drugs in the country. The restructuring of the public sector pharmacies under management of the National Health Fund has helped to streamline procurement and distribution processes. Nevertheless, patients continue to wait long hours for prescriptions to be filled at public pharmacies due to inadequate cadre of pharmacists island wide compounded by increased demand as a result of the abolition of user fees. Due to restrictions in the Government Fiscal space, common drugs used for the treatment of opportunistic infections and STIs are frequently not available in the public sector and

	are too expensive for most patients in the private sector.
The sustainability of the Programme.	Several measures were taken to address the threats to sustainability of the HIV response due to reduced international funding and tightening of the local fiscal space. The integration of components of the National HIV/STI Programme (NHP) into the National Family Planning Board (NFPB) to form one statutory agency with responsibility for sexual and reproductive health will support the sustainability of the HIV Prevention and the Enabling Environment and Rights components. The government has also committed (by way of budgetary allocations) to continue to provide HIV and diagnostic-testing supplies, infant supplementary feeds as well as antiretroviral medication. As part of the efforts to improve sustainability the JABCHA Foundation was relaunched and a new Board of Directors appointed, with the hope that this Foundation will mobilize private sector funding and strengthen the investment approach to funding the HIV response

Challenges faced throughout the 2012 - 2013 reporting period

Many challenges remain for the HIV response overall. These include:

- Linkage, retention and adherence to treatment and care.
- Technical evaluation of impact of interventions to improve scale-up and coverage of key populations.
- Access to prevention services for sexually active minors.
- Policy makers are reluctant to take bold steps to promote an enabling environment that would reduce the vulnerability of those most at risk and better facilitate the provision of services and practice of safer sex, especially for MSM and Adolescents.
- Implementation of integrated Family Planning and HIV services.
- Sustainability of gains made in the HIV response due to limited funding to continue targeting of general population.
- Scale-up of programmes and increase in uptake of HIV testing for MSM.

Concrete remedial actions

- Despite consistently increasing access, the proportion of persons retained in treatment and care has been declining. The TCS unit has developed a linkage and retention protocol to strengthen the retention and linkage process by outlining the roles and responsibilities of treatment site staff, including those involved in outreach testing.
- To ensure scale up of programmes and increased uptake of HIV testing among MSM, the National HIV Programme and the National Family Planning Board - Sexual Health Agency will continue to provide financial and technical support to stakeholders involved in the implementation of the MSM Strategy. The M&E and Prevention units will collaborate to implement planned evaluations of the MSM Strategy with a focus on implementation of the Strategy (process evaluation) as well as outcome evaluation of Empowerment Workshops.
- Policy monitoring consultancy was recently initiated in collaboration with CVC, HPP and UWI HARP to build capacity among Civil Society stakeholders to monitor the development and implementation of policy.
- As part of its integration roadmap the National Family Planning Board, with support from UNAIDS initiated a stakeholder analysis in 2013. The objective of the analysis is to provide crucial information from stakeholders' in a format that can influence an operational plan for the integrated entity. The process involves mapping and ranking of stakeholders, data collection, analysis and reporting. Preliminary results indicate that stakeholders have identified opportunities for a more efficient programme through the provision of wholesome, quality services at a "one stop shop" for clients wishing to access SRH services, strategically engaging stakeholders who are access points to key populations. There is also the opportunity for accessing additional funding sources and capacity building for staff. Stakeholders felt that a detailed communication plan needs to be urgently developed to encourage continued sharing of the integration roadmap. The analysis concludes that engaging the stakeholders throughout the integration process will facilitate the transparency of the process as well as the efficiency and validity of a fully integrated NFPB-SHA.

Support from Country's Development Partners

The national response, led by the National HIV Programme, continues to benefit from access to technical and financial support from key development partners in the multi-sectoral response to the HIV epidemic in Jamaica. The National Response has been primarily financed through a loan agreement with the International Bank for Reconstruction and Development (IBRD/ World Bank), grants from the Global Fund to fight AIDS, Tuberculosis and Malaria (GF) and the United States Agency for International Development President Emergency Plan for AIDS Relief (USAID/PEPFAR) with support from the Government of Jamaica (GOJ).

The NHP along with IDPs continue to reap success from increasing collaboration in the HIV response. The response over the period has been supported by sound technical assistance and advice that has contributed significantly to the achievement of UNGASS targets. The technical interventions have enabled the national response to contain the epidemic with renewed commitment to significantly reduce new infections by 2015.

The four technical components, comprising National Program and Civil Society stakeholders, of the National Response are Prevention, Treatment, Care and Support, Enabling Environment and Human Rights and Monitoring and Evaluation. These technical areas have benefited greatly from the development partners' technical and financial support.

Over the period, M&E component has received support that contributed to end-of-term evaluation of the Strategic Plan; reviewing the TOR for MERG; developing the M&E Framework for MARPs; M&E Leadership and Management training for key stakeholders; evaluation of STI surveillance and revision of STI surveillance forms. Key partners in these activities included PANCAP, CARPHA, MEASURE, USAID, CHAI, and UNAIDS

Key support received by the Prevention component contributed to the completion of VCCT for Minors Legal Analysis Assessment; coordination of the Prevention Technical Working Group; review of findings from MSM and Sex Work survey; development of Positive Health Dignity and Prevention Programme; SRH intervention in State Girls' homes; and the Revised MSM Strategy. Key Partners include USAID, CARTTA, CHAI, UNICEF, UNAIDS, HPP and UNFPA

The EEHR component worked closely with IDP partners to implement initiatives to strengthen the legislative and policy framework. Key support contributed to the drafting of the HIV Regulations and OSH Act, development/drafting of PHDP Manual for use in capacity building workshops with GIPA unit, cluster consultations for Justice for All, development of Faith-based intervention manual and docudramas; and the High-level leadership Breakfast in 2012. Key Partners include HPP, CVC, UWI-HARP, UNAIDS, PANCAP, UNDP, and USAID

During 2012, the Treatment, Care and Support component received support to finalize the HIV Management Manual; review Laboratory services; develop databases at the NPHL for CD4 and PCR data management; pMTCT and eMTCT initiative; and finalise an ARV costing tool. Key Partners include, CHAI, CDC, AHF, USAID, GF, UNICEF, UNAIDS, PAHO, and CHART

Monitoring & Evaluation Environment

In 2004, the NHP established an M&E Unit to track the progress of the National Strategic Plan and hence, Jamaica's HIV response. Guided by the M&E Plan, the M&E system has been implemented and has supported the national response. Despite many achievements, important gaps remain that must be addressed to achieve a fully functioning M&E system

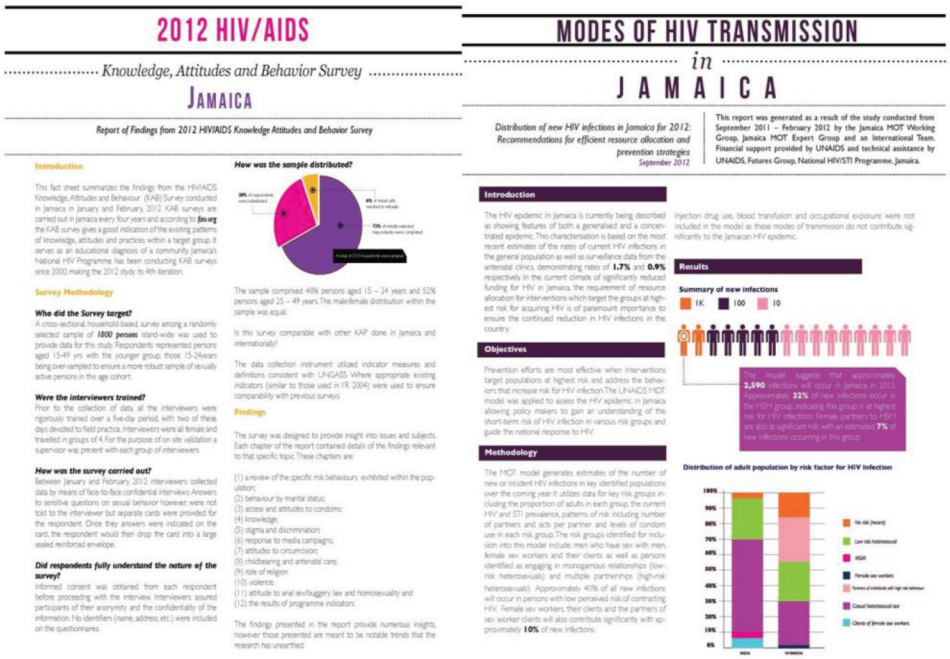
Achievements

Some key activities that the M&E Unit has participated in to strengthen the M&E system during the 2012 – 2013 period include:

- PANCAP STI Surveillance Assessment was completed in 2012, which reviewed the quality of the STI surveillance system to identify key areas for improvement. Since this assessment, a national technical working group has been established which is working on streamlining the data collection forms and methodologies with a view to strengthen and increase the available data for STI management.
- The M&E Unit in collaboration with Monitoring and Evaluation to Assess and Use Results (MEASURE Evaluation) facilitated a 3-day workshop on Leadership in Data Demand & Use. The workshop aimed to define the role of leadership in promoting sustainable data use, raise awareness of the importance of data in decision making, apply leadership practices in building individual and team capacity to apply data demand and use concepts, approaches, and tools; and promote and sustain them through strong leadership. Additionally, the workshop helped develop specific plans to use data in decision making and overcome barriers to data use. Participants included key persons responsible for data use in regional health authorities and civil society.
- The HIV Case-Based Surveillance Manual was completed and disseminated to stakeholders involved in the diagnosis and reporting of HIV cases. The manual was developed with support by PAHO, CDC, and USAID.
- The Caribbean Public Health Agency (CARPHA), alongside the team from MEASURE Evaluation (University of North Carolina), conducted a pilot of Country Ownership of M&E system tool in Jamaica. This tool looked at country ownership as defined by the dimensions of 1) power, legitimacy and respect; 2) commitment and responsibility, 3) capacity and 4) accountability. The implementation of recommendations from this process will contribute to the development of a higher functioning and more sustainable M&E system that will produce better data and ultimately lead to better programmatic and policy decision making.
- The Terms of Reference for the Monitoring and Evaluation Reference Group was revised guidance to strengthen its ability to provide guidance to the National HIV response in the generation, dissemination and use of HIV strategic information and fosters functional M&E performance in Jamaica.

- Improved the level of supportive supervision to the adult treatment sites through field visits, encouraging the systematic processes for data management in order to improve the timeliness of database entries, and improve the understanding of inputs and outputs of the database to guide patient management. Protocol developed to guide site visits.
- Through the support of the Clinton Health Access Initiative (CHAI), a "Database Sweep" was done across all the adult treatment sites, ensuring all critical data points (for every clinic visit since diagnosis) were up to date for each patient seen at the treatment site since 2010 through 2012. Guided by this activity and information from the database, the data entry screen was revised to reflect the critical points and an accompanying intake tool developed to facilitate the collection and entry of critical data points.
- In response to stakeholder requests, new modules and reports were added to the treatment site database to further support the use of the electronic ARV registry and strengthen the tracking of indicators for the treatment cascade.
- The M&E Unit facilitated internet connectivity through provision of hardware at some treatment sites to assist with the networking capacity at sites and the secure wireless submission of data to the M&E Unit. This will ensure that a backup copy of the data entered at all treatment sites is available at the national level and will make possible the merging of data to have a centralized treatment site database that is better able to track patient movements across sites.
- Increased operational research occurred, including the Modes of Transmission study which was completed with the assistance of UNAIDS, and a pilot using mobile health technology (mHealth). The mHealth pilot was completed in three of the four health regions (2 trial regions and 1 control region) and provided validity checks of the data collected in outreach activities.
- The M&E Unit collaborated with the Caribbean Region Public Health Agency to complete an end of term evaluation of the Prevention and Enabling Environment components of the National Strategic Plan. This evaluation provided useful information the components efforts and performance and also built local evaluation capacity.
- Increase data dissemination and feedback to sub-recipients, in the form of Indicator Updates (eg. Global Fund Bulletin) and Fact Sheet Summaries of all major reports were distributed at the 2012 Annual review (Figure 11). Presentations were made at national meetings as well as component led meetings.

  These achievements have improved the availability of high quality data for use in strategic planning.



2012 HIV/AIDS

Knowledge, Attitudes and Behavior Survey

JAMAICA

Report of Findings from 2012 HIV/AIDS Knowledge Attitudes and Behavior Survey

Introduction

This fact sheet summarizes the findings from the HIV/AIDS Knowledge, Attitudes and Behaviour (KAB) Survey conducted in Jamaica in January and February, 2012. KAB surveys are carried out in Jamaica every four years and according to the KAB survey gives a good indication of the existing patterns of knowledge, attitudes and practices within a target group. It serves as an educational diagnosis of a community. Jamaica's National HIV Programme has been conducting KAB surveys since 2000, making the 2012 study its 4th iteration.

Survey Methodology

Who did the Survey target?

A cross-sectional, household-based, survey among a randomly selected sample of **1800 persons** island-wide was used to provide data for this study. Respondents represented persons aged 15-49 yrs with the younger group, those 15-24years being over-sampled to ensure a more robust sample of sexually active persons in this age cohort.

Were the interviewers trained?

Prior to the collection of data, all the interviewers were rigorously trained over a five-day period, with two of these days devoted to field practice. Interviewers were all female and travelled in groups of 4. For the purpose of on site validation a supervisor was present with each group of interviewers.

How was the survey carried out?

Between January and February, 2012, interviewers collected data by means of face-to-face confidential interviews. Answers to sensitive questions on sexual behavior however, were not told to the interviewer but separate cards were provided for the respondent. Once they answers were indicated on the card, the respondent would then drop the card into a large sealed reinforced envelope.

Did respondents fully understand the nature of the survey?

Informed consent was obtained from each respondent before proceeding with the interview. Interviewers assured participants of their anonymity and the confidentiality of the information. No identifiers (name, address, etc.) were included on the questionnaires.

How was the sample distributed?

The sample comprised 48% persons aged 15 – 24 years and 52% persons aged 25 – 49 years. The male:female distribution within the sample was equal.

Is this survey comparable with other KAP done in Jamaica and internationally?

The data collection instrument utilized indicator measures and definitions consistent with UNGASS. Where appropriate existing indicators (similar to those used in IYR 2004) were used to ensure comparability with previous surveys.

Findings

The survey was designed to provide insight into issues and subjects. Each chapter of the report contained details of the findings relevant to that specific topic. These chapters are:

(1) a review of the specific risk behaviours exhibited within the population;
(2) behaviour by marital status;
(3) access and attitudes to condoms;
(4) knowledge;
(5) stigma and discrimination;
(6) response to media campaigns;
(7) attitudes to circumcision;
(8) childbearing and antenatal care;
(9) role of religion;
(10) violence;
(11) attitude to anal sex/buggery law and homosexuality and
(12) the results of programme indicators.

The findings presented in the report provide numerous insights, however those presented are meant to be notable trends that the research has unearthed.

MODES OF HIV TRANSMISSION

in

JAMAICA

Distribution of new HIV infections in Jamaica for 2012: Recommendations for efficient resource allocation and prevention strategies

September 2012

This report was generated as a result of the study conducted from September 2011 – February 2012 by the Jamaica MOT Working Group, Jamaica MOT Expert Group and an International Team. Financial support provided by UNAIDS and technical assistance by UNAIDS, Futures Group, National HIV/STI Programme, Jamaica.

Introduction

The HIV epidemic in Jamaica is currently being described as showing features of both a generalised and a concentrated epidemic. This characterisation is based on the most recent estimates of the rates of current HIV infections in the general population as well as surveillance data from the antenatal clinics, demonstrating rates of **1.7%** and **0.9%** respectively. In the current climate of significantly reduced funding for HIV in Jamaica, the requirement of resource allocation for interventions which target the groups at highest risk for acquiring HIV is of paramount importance to ensure the continued reduction in HIV infections in the country.

Objectives

Prevention efforts are most effective when interventions target populations at highest risk and address the behaviors that increase risk for HIV infection. The UNAIDS MOT model was applied to assess the HIV epidemic in Jamaica allowing policy makers to gain an understanding of the short-term risk of HIV infection in various risk groups and guide the national response to HIV.

Methodology

The MOT model generates estimates of the number of new or incident HIV infections in key identified populations over the coming year. It utilizes data for key risk groups including the proportion of adults in each group, the current HIV and STI prevalence, patterns of risk including number of partners and acts per partner and levels of condom use in each risk group. The risk groups identified for inclusion into this model include: men who have sex with men, female sex workers and their clients as well as persons identified as engaging in monogamous relationships (low-risk heterosexuals) and multiple partnerships (high-risk heterosexuals). Approximately 40% of all new infections will occur in persons with low perceived risk of contracting HIV. Female sex workers, their clients and the partners of sex worker clients will also contribute significantly with approximately **10%** of new infections.

Injection drug use, blood transfusion and occupational exposure were not included in the model as these modes of transmission do not contribute significantly to the Jamaican HIV epidemic.

Results

Summary of new infections

1K 100 10

The model suggests that approximately **2,590** infections will occur in Jamaica in 2012. Approximately **32%** of new infections occur in the MSM group indicating this group is at highest risk for HIV infections. Female partners to MSM are also at significant risk, with an estimated **7%** of new infections occurring in this group.

Distribution of adult population by risk factor for HIV infection

100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0%

MEN WOMEN

.Figure 12: Sample of fact sheets on major research that were disseminated at 2012 Annual HIV Program Review

Challenges

Finalization of a Revised National Strategic Plan: In April 2013, the integration of the National HIV/STI Programme (NHP) into the National Family Planning Board (NFPB) to form one executive Sexual Health Agency was formalized. This agency has responsibility for sexual and reproductive health and will support the sustainability of the HIV Prevention and the Enabling Environment and Human Rights components. However, a revised national strategic and monitoring plan that incorporates the priorities of the HIV response within the broader national sexual and reproductive health agenda has not yet been finalized.

M&E Capacity and Accountability at Sub-National Levels: The Country Ownership of M&E Systems Tool identified that although there is strong ownership of the M&E system in Jamaica, areas for improvement were capacity and accountability at sub-national levels. Capacity considers existing and planned human capacity, existing physical capacity and leadership and management of capacity while accountability considers data management systems around established guidelines, data capture, storage and

information flow and feedback. Very few stakeholders have a committed M&E position, and even fewer have developed M&E plans for their programmes.

Databases: Substantial work has been done with the staff at the adult treatment sites, which has led to improvements in the usefulness and accuracy of the data that is able to be easily captured and analysed. However, the paediatric treatment sites have not as yet benefited from the level of training and support for utilization of the database for paediatric clients. Therefore, while M&E will continue to strengthen and encourage the data management systems at the adult treatment sites for further improvement, priority will also have be given to the paediatric sites to improve the capacity to track these patients and monitor their clinical management through our services. The EMTCT database subcommittee will provide technical support for this activity.

Data collection: Disaggregated data on some key indicators are still unavailable, limiting the understanding of access to services by key populations, men and women, as well as boys and girls. The unit has allocated funds towards developing a unique identifier system for key populations, and collecting bio-behavioural data for key populations, including adolescents and youth. Strategies to address the policy barrier to testing youth are being explored.

Remedial Actions

In November 2013, joint stakeholders from the Ministry of Health, the National Famiy Planning Board - Sexual Health Agency, various line ministries and civil society at the 1st Annual Review of the Sexual Health Agency worked in assigned small groups to contribute to the development of the integrated strategic plan. Each group identified strategies to improve on the strengths and address the gaps and weaknesses that were identified. Going forward, a committee has been established to continue the revision and monitor inclusion of feedback in the revised strategic plan.

Other specific activities that have been prioritized for implementation in 2014-2015 include:

2014-2015

- Conduct additional behavioural surveillance research studies to justify continued support of interventions with key populations.
- Finalize the integrated national strategic plan and accompanying M&E Operational plan.
- Review and prioritize recommendations from the evaluations of the Prevention and Enabling Environment components.
- Conduct training workshops in data quality management; and also evaluation, research and data analysis.

- Formalize terms of reference and composition for the small working groups of the MERG and the accompanying workplans.

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Annex 1: Preparation Process for Jamaica's Global AIDS Response Report, 2014

This report draws heavily on the NSP 2012-2017 (Ministry of Health, 2012) and the accompanying M&E Plan, which were developed through extensive consultative processes. The M&E plan describes monitoring tools and special studies implemented by stakeholders to inform the indicators.

The Draft Progress Report was presented to stakeholders to gain consensus on the completed inputs. The National Validation Meeting was held on March 26th, 2014 and included working groups organized around Prevention, Policy and Legislative Framework and Treatment, Care and Support. M&E, financing of the national response and impact alleviation were discussed in each group as crosscutting issues. Participants included 42 key Government and civil society stakeholders, bilateral agencies including UN and academia. The compiled report is reviewed and edited based on stakeholder consultations. Timelines are summarized below.

Activity	Start Date	Completion date
Identify data needs in line with the national strategic plan requirements and these reporting guidelines.	March 2012	March 2014
Develop a plan for data collection, analysis and report writing	January 2014	March 2014
Secure required funding for the entire process of collecting, analysing and reporting the data.	January 2013	February 2014
Collect and collate and analyses data in coordination with partner organizations	May 2013	March 2014
Draft the Country Progress Report narrative	February 2014	March 2014
Allow stakeholders, including government agencies and civil society, to comment on the draft report.	March 25, 2014	March 28, 2014
Validate data against the narrative and enter it into the UNGASS reporting website	March 23, 2012	March 30, 2012
Submit (i) the narrative report and (ii) the indicator data to UNAIDS Geneva before 31 March		March 31,2012

Annex 2: NCPI – Trend Analysis 2003-2013 (Table)

NCPI Key Indicators	Reporting Year					
	2003	2005	2007	2009	2011	2013
Part A						
I. Strategic Plan						
Country has developed a national multi-sectoral strategy/action framework to combat HIV/AIDS	-	Yes	Yes	Yes	Yes	Yes
Country has integrated HIV/AIDS into its general development plans	-	Yes	Yes	Yes	Yes	Yes
Country has evaluated the impact of HIV and AIDS on its socio economic development for planning purposes	-	Yes	Yes	No	No	Yes
Country has a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services, military, peacekeepers and police	-	Yes	Yes	Yes	Yes	Yes
Strategy planning efforts in the HIV and AIDS programmes overall rating	7	8	8	9	8	8
II. Political Support and Leadership						
The head of the government and/or other high officials speak publicly and favourably about AIDS efforts at least twice a year	-	Yes	Yes	Yes	Yes	Yes
Country has a national multi-sectoral HIV and AIDS management/coordination body recognized in law? (National AIDS Council or Commission)	-	Yes	Yes	Yes	Yes	Yes
Country has a national HIV and AIDS body that promotes interaction between government, people living with HIV, the private sector and civil society for implementing HIV and AIDS strategies/programmes	-	Yes	Yes	Yes	Yes	Yes

NCPI Key Indicators	Reporting Year					
	2003	2005	2007	2009	2011	2013
Country has a national HIV and AIDS body that is supporting coordination of HIV-related service delivery by civil-society organizations	-	Yes	Yes	Yes	Yes	Yes
Political support for the HIV/AIDS programme overall rating	-	7	8	7	7	8
III. Human Rights (section included as of 2011)						
Country have a general (i.e. not specific to HIV-related discrimination) law on non-discrimination	-	-	-	-	Yes	Yes
Country have laws, regulation or policies that present obstacles to effective HIV prevention, treatment care and support for key populations and vulnerable group.	-	-	-	-	Yes	Yes
IV. Prevention						
Country has a policy or strategy that promotes information, education and communication (IEC) on HIV and AIDS to the general population	-	Yes	Yes	Yes	Yes	Yes
Country has a policy or strategy promoting HIV and AIDS related reproductive and sexual health education for young people (age appropriate)	-	Yes	Yes	Yes	Yes	Yes
Country has a policy or strategy to promote and other preventive health interventions for most-at-risk populations (out of school youth added in 2011)	-	Yes	Yes	Yes	Yes	Yes
Country has a policy or strategy to expand access, including among most-at-risk populations, to essential preventative commodities.	-	Yes	Yes	Yes	Yes	Yes
Policy efforts in support of prevention overall rating	4	6	7	6	7	7
Prevention activities have been implemented during the period in support of the HIV-prevention policy/strategy	Yes	Yes	Yes	Yes	Yes	Yes

NCPI Key Indicators	Reporting Year					
	2003	2005	2007	2009	2011	2013
Efforts in the implementation of HIV prevention programmes overall rating	6	7	8	9	8	8
V. Treatment, Care and Support						
Activities have been implemented under the care and treatment of HIV and AIDS programmes	Yes	Yes	Yes	Yes	Yes	Yes
Efforts in care and treatment of the HIV/AIDS programme overall rating	6	8	9	9	6	7
Country has a policy or strategy to address the additional HIV and AIDS-related needs of orphans and other vulnerable children (OVC)	-	Yes	Yes	Yes	Yes	Yes
Efforts to meet the needs of orphans and other vulnerable children overall rating	6	7	8	7	5	5
VI. Monitoring and Evaluation						
Country has one national Monitoring and Evaluation plan	-	IP	Yes	Yes	Yes	Yes
There is a budget for the Monitoring and Evaluation plan	-	Yes	Yes	Yes	Yes	Yes
There is a Monitoring and Evaluation functional Unit or Department	-	Yes	Yes	Yes	Yes	Yes
There is a committee or working group that meets regularly coordinating Monitoring and Evaluation activities	-	IP	Yes	Yes	Yes	Yes
Individual agency programmes have been reviewed to harmonize Monitoring and Evaluation indicators with those of your country	-	Yes	Yes	Yes	Yes	Yes
Degree (Low to High) to which UN, bi-laterals, other institutions are sharing M&E results 2005-7/Mechanism in place to ensure all key players submit M&E data/reports to M&E unit for inclusion in the national M&E system	-	6/10	4 /5	Yes	Yes	Yes
The Monitoring and Evaluation Unit manages a central national database	-	Yes	Yes	Yes	Yes	Yes
There is a functional Health Information System	-	Yes	No	Yes	Yes	Yes

NCPI Key Indicators	Reporting Year					
	2003	2005	2007	2009	2011	2013
Country publishes at least once a year an evaluation report on HIV and AIDS, including HIV surveillance reports	-	Yes	Yes	Yes	Yes	Yes
Extent to which strategic information is used in planning and implementation? (*Not measured as of 2011*)	-	8/10	4/5	4/5	-	-
In the last year, training in Monitoring and Evaluation was conducted	-	Yes	Yes	Yes	Yes	Yes
Monitoring and evaluation efforts of the HIV and AIDS programme overall rating.	6	7	9	9	8	8
Part B						
I. Civil Society Involvement						
Extent to which civil society has made a significant contribution to strengthening the political commitment of top leaders and national policy formulation	-	8/10	2 /5	3/5	3/5	3/5
Extent to which civil society representatives have been involved in the planning and budgeting process for the National Strategic Plan on HIV and AIDS or for the current activity plan (attending planning meetings and reviewing drafts)	-	7/10	2/5	3/5	3/5	3/5
Extent to which the complimentary services provided by civil society to areas of prevention and care are included in both the National Strategic (i) plans, (ii) reports and (iii) budget.	-	7/10	3/5	(i) 4/5	(i) 4/5	(i) 4/5
				(ii) 3/5	(ii) 4/5	(ii) 4/5
				(iii) 3/5	(iii) 3/5	(iii) 3/5
Country has conducted a National Periodic review of the Strategic Plan with the participation of civil society (2003 – 2005) Extent to which civil society is included in M&E of HIV response? (i) Developing M&E plan, (ii) MERG participation, (iii) local level use/data decision-making	-	Yes	Yes	(i) 3/5	(i) 4/5	(i) 3/5
				(ii) 3/5	(ii) 3/5	(ii) 3/5
				(iii) 3/5	(iii) 3/5	(iii) 3/5
Civil Society sector representation in HIV efforts inclusive of diverse organizations				4/5	4/5	4/5

NCPI Key Indicators	Reporting Year					
	2003	2005	2007	2009	2011	2013
Extent to which civil society is able to access adequate (i) financial support (ii) technical support to implement HIV activities	-	-	-	(i) 3/5 (i) 3/5	(i) 3/5 (ii) 2/5	(i) 3/5 (ii) 3/5
Efforts to increase civil-society participation overall rating	5	8	8	7	8	9
II. Political Support and Leadership						
Has the country, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in government HIV policy design and programme implementation	-	-	-	-	Yes	Yes
III. Human Rights						
Country has laws and regulations *(policy)* that protect people living with HIV and AIDS against discrimination (the word policy was added 2011)	-	Yes	No	No	Yes	Yes
Country has non-discrimination laws or regulations *(policy)* which specify protections for certain groups of people identified as being especially vulnerable to HIV and AIDS discrimination (the word policy was added 2011)	-	No	Yes	No	Yes	Yes
Country has a general (i.e. not specific to HIV –related discrimination) law on non-discrimination.	-	-	-	-	Yes	Yes
Country has laws and regulations that present obstacles to effective HIV prevention and care for most-at-risk populations	-	No	Yes	Yes	Yes	Yes
The promotion and protection of human rights is explicitly mentioned in an HIV and AIDS policy/strategy	-	Yes	Yes	Yes	Yes	Yes
The Government has, through political and financial support, involved vulnerable populations in governmental HIV-policy design and	-	Yes	Yes	Yes	Yes	Yes

NCPI Key Indicators	Reporting Year					
	2003	2005	2007	2009	2011	2013
programme implementation (*now captured in section 2 – Political Support and Leadership*)						
Country has a policy to ensure equal access, between men and women, to prevention and care	-	Yes	Yes	Yes	No	Yes
Country has a policy to ensure equal access to prevention and care for most-at-risk populations	-	Yes	Yes	Yes	No	Yes
Country has a policy prohibiting HIV screening for general employment purposes (appointment, promotion, training, benefits)	-	Yes	Yes	Yes	Yes	Yes
Country has a policy to ensure that HIV and AIDS research protocols involving human subjects are reviewed and approved by a national/local ethical review committee (*Question not included in 2014*)	-	Yes	Yes	Yes	Yes	Yes
Members of the judiciary have been trained/sensitized to HIV and AIDS and human rights issues that may come up in the context of their work	-	No	Yes	Yes	Yes	Yes
Legal support services are available in the country (*Question is more specific in the questionnaire*)	-	Yes	Yes	Yes	Yes	Yes
There are programmes designed to change societal attitudes of discrimination and stigmatization associated with HIV and AIDS to understanding and acceptance	-	Yes	Yes	Yes	Yes	Yes
Policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS overall rating	-	5	6	6	5	5
Effort to enforce the existing policies, laws and regulations overall rating	-	3	4	5	5	5
IV. Prevention						

NCPI Key Indicators	Reporting Year					
	2003	2005	2007	2009	2011	2013
Prevention activities have been implemented in support of the HIV-prevention policy/strategy	Yes	Yes	Yes	Yes	Yes	Yes
Efforts in the implementation of HIV prevention programmes overall rating	6	7	-	8	6	7
V. Treatment, Care and Support						
Activities have been implemented under the care and treatment of HIV and AIDS programmes	Yes	Yes	Yes	Yes	Yes	Yes
Efforts in care and treatment of the HIV/AIDS programme overall rating	6	9	8	8	7	7
Country has a policy or strategy to address the additional HIV and AIDS-related needs of orphans and other vulnerable children (OVC)	-	Yes	Yes	Yes	Yes	Yes
Efforts to meet the needs of orphans and other vulnerable children overall rating	5	8	8	5	4	2

Annex 3 Size Estimations for Key Populations

Key population	Size estimation performed (yes/no)	If yes, when was the latest estimation performed? (year)	If yes, what was the size estimation?
a)Men who have sex with men	Y	2012	(4.5% of male population) 33000
b) Female sex workers	Y	2014	(2.5% of female population) 18,696
c)Homeless drug users	Y	2012	1600
d) Inmates	Y	2013	5000
e)Out of School Youth	Y	2012	141,744

Annex 4 Participants in NCPI and GARPR Consultations

List of Attendees Consultation #1
Tuesday February 25, 2014

Organization	Representative
National HIV/STI Programme (NHP)	Dr. Nicola Skyers
Department of Correctional Services	Dr. Donna Royer-Powe
National Family Planning Board – Sexual Health Agency (NFPB-SHA)	Dr. Sharlene Jarrett
Bureau of Women's Affairs (BWA)	Karen Small
National Family Planning Board – Sexual Health Agency (NFPB-SHA)	Karlene Temple-Anderson
Ministry of Labour and Social security (MLSS)	Robert Chung
National Council on Drug Abuse (NCDA)	Jhanille Brooks
South East Regional Health Authority (SERHA)	Dr. Heather Reid-Jones
National HIV/STI Programme (NHP)	Zahra Miller
Joint United Nations Programme on HIV/AIDS (UNAIDS)	Erva Jean Stevens
Health Policy Project/Futures Group	Kerian Richards-Gray
Children First	Claudette Pious
JN Plus	Devon Gabourel
Jamaica AIDS Support for Life (JASL)	Kandasi Levermore
Hope Worldwide	Karen Daye
Clinton Health Access Initiative	Ingrid Thame
The Jamaica Forum of Lesbians, All-Sexual and Gays (JFLAG)	Jaevion Nelson
Caribbean Vulnerable Communities (CVC)	Ivan Cruickshank
Charles Drew University/Jamaica Defence Force (CDU/JDF)	Terry Myrie
National HIV/STI Programme (NHP)	Sasha Martin
Caribbean Vulnerable Communities (CVC)	Dr. Ingrid Cox-Pierre
NCPI Consultant	Suzanne Robinson-Davis
Jamaica Community of Positive Women	Olive Edwards
National Family Planning Board – Sexual Health Agency (NFPB-SHA)	Christine-Ann McKen
National Family Planning Board – Sexual Health Agency (NFPB-SHA)	Deandra Williams
Jamaica Youth Advocacy Network (JYAN)	Peita-Gaye Whyte
National Family Planning Board – Sexual Health Agency (NFPB-SHA)	Judith Fishley
JN Plus	Michael Henry
Jamaica AIDS Support for Life (JASL)	Kristina Mena
National Family Planning Board – Sexual Health Agency (NFPB-SHA)	Nicola Cousins
National Family Planning Board – Sexual Health Agency (NFPB-SHA)	Juliet Hall

List of Attendees Consultation #2
Wednesday March 19, 2014

Organization	Representative
National HIV/STI Programme (NHP)	Dr. Nicola Skyers
Department of Correctional Services	Dr. Donna Royer-Powe
National Family Planning Board - Sexual Health Agency (NFPB-SHA)	Dr. Sharlene Jarrett
Bureau of Women's Affair (BWA)	Karen Small
National Family Planning Board - Sexual Health Agency (NFPB-SHA)	Karlene Temple-Anderson
National Council on Drugs Abuse	Jhanille Brooks
Joint United Nations Programme on HIV/AIDS (UNAIDS)	Erva Jean Stevens
Health Policy Project/Futures Group	Kerian Richards-Gray
Jamaica AIDS Support for Life (JASL)	Kandasi Levermore
Hope Worldwide	Karen Daye
Clinton Health Access Initiative	Ingrid Thame
National HIV/STI Programme (NHP)	Sasha Martin
Caribbean Vulnerable Communities (CVC)	Dr. Ingrid Cox-Pierre
NCPI Consultant	Suzanne Robinson-Davis
National Family Planning Board - Sexual Health Agency (NFPB-SHA)	Christine-Ann McKen
National Family Planning Board - Sexual Health Agency (NFPB-SHA)	Judith Fishley
National Family Planning Board - Sexual Health Agency (NFPB-SHA)	Nicola Cousins
Eve for Life	Patricia Watson
World Learning	Ruth Jankee
Eve for Life	Joy Crawford
Caribbean HIV/AIDS Regional Training Network (CHART - ERTU)	Dr. Tina Hylton-Kong
National Family Planning Board – Sexual Health Agency (NFPB-SHA)	Audi Reid-Brevett
South East Regional Health Authority (SERHA)	Dr. Melody Ennis
United Nations Educational, Scientific and Cultural Organization (UNESCO)	Jenelle Babb
National HIV/STI Programme (NHP)	Dr. Jeremy Knight
National Family Planning Board - Sexual Health Agency (NFPB-SHA)	Sannia Sutherland

List of Attendees NCPI Consultation #3
Monday March 24, 2014

Organization	Representative
National Family Planning Board - Sexual Health Agency (NFPB-SHA)	Dr. Sharlene Jarrett
National Family Planning Board - Sexual Health Agency (NFPB-SHA)	Karlene Temple-Anderson
Hope Worldwide	Karen Daye
National HIV/STI Programme (NHP)	Sasha Martin
NCPI Consultant	Suzanne Robinson-Davis
National Family Planning Board - Sexual Health Agency (NFPB-SHA)	Christine-Ann McKen
National Family Planning Board - Sexual Health Agency (NFPB-SHA)	Nicola Cousins
World Learning	Ruth Jankee
National Family Planning Board - Sexual Health Agency (NFPB-SHA)	Audi Reid-Brevett
National Family Planning Board - Sexual Health Agency (NFPB-SHA)	Sannia Sutherland
Children First	Claudette Richardson-Pious
Jamaica Youth Advocacy Network (JYAN)	Javan Campbell
National AIDS Committee (NAC)	Carla Bingham-Ledgister

List of Attendees (GARPR Consultation)
Wednesday March 26, 2014

Organization	Representative
National Family Planning Board - Sexual Health Agency (NFPB-SHA)	Dr. Sharlene Jarrett
National Family Planning Board - Sexual Health Agency (NFPB-SHA)	Karlene Temple-Anderson
National Council on Drug Abuse (NCDA)	Jhanille Brooks
Joint United Nations Programme on HIV/AIDS (UNAIDS)	Erva Jean Stevens
Health Policy Project/Futures Group	Kerian Richards-Gray
Children First	Claudette Pious
JN plus	Devon Gabourel
Jamaica AIDS Support for Life (JASL)	Kandasi Levermore
Hope Worldwide	Karen Daye
Clinton Health Access Initiative	Ingrid Thame
The Jamaica Forum of Lesbians, All-Sexual and Gays (JFLAG)	Jaevion Nelson
National HIV/STI Programme (NHP)	Sasha Martin
NCPI Consultant	Suzanne Robinson-Davis
National Family Planning Board - Sexual Health Agency (NFPB-SHA)	Christine-Ann McKen
National Family Planning Board - Sexual Health Agency (NFPB-SHA)	Deandra Williams
National Family Planning Board - Sexual Health Agency (NFPB-SHA)	Judith Fishley
National Family Planning Board - Sexual Health Agency (NFPB-SHA)	Nicola Cousins
Pan American Health Organization (PAHO)	Dr. Kam Mung
National Family Planning Board - Sexual Health Agency (NFPB-SHA)	Ainsley Reid
The United Nations International Children's Fund (UNICEF)	Novia Condell-Gibson
United Nations Educational, Scientific and Cultural Organization (UNESCO)	Jenelle Babb
Eve for Life	Patricia Watson
National HIV/STI Programme (NHP)	Dr. Jeremy Knight
Jamaica Youth Advocacy Network (JYAN)	Javan Campbell
United Nations Population Fund (UNPFA)	Marvin Gunter
Ministry of Health	Nicole Chen
Joint United Nations Program on HIV/AIDS (UNAIDS)	Kate Spring
National Family Planning Board - Sexual Health Agency (NFPB-SHA)	Deandra Williams
UWI, Mona HIV/AIDS Response Programme (UWI-HARP)	Courtney Liebi
National AIDS Committee (NAC)	Carla Bingham-Ledgister
North East Regional Health Authority (NERHA)	Patricia Russell
Ministry of Labour and Social Security (MLSS)	Peta-Gay Pryce
National Family Planning Board - Sexual Health Agency (NFPB-SHA)	Sannia Sutherland
Ministry of Labour and Social Security (MLSS)	Andrew Dale
The Jamaica Forum of Lesbians, All-Sexual and Gays (JFLAG)	Brian-Paul Welsh
UWI, Mona HIV/AIDS Response Programme (UWI-HARP)	Yolanda Paul
University Hospital of the West Indies (UWI) - CHARES	Dr. Geoffrey Barrow
Southern Regional Health Authority (SRHA)	Dr. Vitillius Holder
National Family Planning Board - Sexual Health Agency (NFPB-SHA)	Audi Reid-Brevett
Southern Regional Health Authority (SRHA)	Diana Johnson
Southern Regional Health Authority (SRHA)	Larenzo Badalo
UWI, Mona HIV/AIDS Response Programme (UWI-HARP)	Dr. Marjan de Bruin