National HIV/STD Control Programme

Business tycoons support HIV/AIDS through the Jamaica Business Council on HIV/AIDS (JABCHA) formed on September 26, 2006

Annual Report

January to December 2006

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Acronyms

ACC	Adult Correctional Centres
AIDS	Acquired Immune Deficiency Syndrome
ANC(s)	Antenatal clinic(s)
ART	Antiretroviral therapy
ARV	Antiretroviral
CCC	Caribbean Conference of Churches
CHC	Comprehensive Health Centre
CSW	Commercial Sex Workers
BSS	Behavioural Surveillance Surveys
ERTU-CHART	Epidemiology Research and Training Unit of The Caribbean HIV/AIDS Regional Training network
FBO	Faith Based Organization
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HFLE	Health and Family Life Education
HIV	Human Immunodeficiency Virus
JCC	Juvenile Correctional Centres
LIS	Laboratory Information System
M&E	Monitoring and Evaluation
MLGCD	Ministry of Local Government &Community Development
MNS	Ministry of National Security
MOEYC	Ministry of Education Youth and Culture
MSM	Men who have sex with men
MTCT	Mother-to-child transmission
NAC	National AIDS Committee
NHP	National HIV/STI Programme
NGO(s)	Nongovernmental organization(s)
NHF	National Health Fund
NSP	National Strategic Plan
OVC	Orphans and Other Vulnerable Children
PAA(s)	Parish AIDS Association(s)
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
STI(s)	Sexually transmitted infection(s)
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
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
VCT	Voluntary Counselling and Testing

Acknowledgements

Dr. Debbie Carrington and Faith Hamer compiled this report. Staff and stakeholders from the National HIV/STI Programme, the Ministry of Health including regional health authorities, the National AIDS Committee with its members and partners provided annual reports, which were incorporated into this document. Specially targeted groups and individuals involved in the national HIV/AIDS response also provided support and information.

Overview of the HIV Epidemic in Jamaica

After nearly two decades of attacking HIV/AIDS aggressively in Jamaica, a downward trend is emerging in some AIDS statistics. Jamaica experienced an 18 per cent decline in reported deaths due to AIDS during 2006 compared with 2005. At the end of December 2006, Jamaica also recorded a six per cent decrease in reported paediatric AIDS cases against 2005 data and a 46 per cent drop in the number of deaths among children with AIDS. This diminishing trend is also showing up in mother-to-child or vertical transmission of HIV. The reported AIDS cases through vertical transmission went down by 10 per cent in 2006 compared with 29 per cent in 2002.

Over the next few years, this decreasing trend in figures deserves more than cursory recognition after many years of tackling prevention, treatment and discrimination reduction. Except for the noted dramatic decline in some sexually transmitted infections (STI), progress has been often reflected in the slowed HIV prevalence rate (1.5 per cent) and the expanded outputs such as increased condom-use, condom access and improved access to antiretrovirals (ARVs) for people living with HIV. While this kind of progress has helped to avert over 100,000 new HIV infections, a more dramatic pattern of decline is still desired.

Surveillance data suggest that men and women with AIDS in Jamaica are living longer. Within 2006, there were 432 reported deaths due to AIDS compared to 514 in 2005, reflecting an 18 per cent drop in reported AIDS deaths.

The proportion of children in Jamaica up to nine years old reported with AIDS is also going down. The actual figures show movement from 78 in 2005 to 73 at the end of 2006. New paediatric AIDS deaths reported within the same period, accounted for 13 in 2006 with 19 reported in 2005.

This emerging slide must be examined within the broader context of other noteworthy achievements such as expanded accessibility and affordability for antiretroviral (ARV) treatment; the decline in the incidence of STIs and syndromes, the prevention of mother-to-child transmission of HIV, the expansion of voluntary counselling and testing (VCT) services, and years of behaviour change communication strategies and interventions.

Expanded multisectoral involvement and reduced HIV-related discrimination have also helped to free up access to prevention knowledge and treatment services.

There is however, no room for complacency. Jamaica needs to achieve universal access to prevention services and treatment and care so that the emerging decline will become a reality. The desired reality is that the downward trend will

be reflected not just in the number of reported AIDS deaths but also incidence of HIV.

Drop in AIDS Deaths and Programme Impact

Nevertheless, there is definitely a correlation between the decline in reported paediatric cases and the increased HIV testing for pregnant women among other programmatic interventions. During 2006, the National HIV/STI Programme (NHP) expanded the coverage for HIV testing of pregnant women under the Prevention of Mother-To-Child Transmission (PMTCT) programme.

In addition, the number of persons on antiretroviral treatment moved from 100 in 2004 to 3000 in 2006. Also, at the end of 2006, ninety-seven per cent of the intended population under the PMTCT programme was tested compared to 39 per cent in 2003. This coverage was among the factors moving the vertical transmission rate to 10 per cent in 2006 from 29 per cent in 2002.

Narrowing Gap

Although Jamaica continues to experience increasing HIV incidence from year to year, the gap narrowed over the period 2004 to 2006. There was a mere 1.58 per cent increase in the number of adults reported with AIDS up to 2006 over 2005, compared with a 20 per cent increase in 2005 over 2004. In actual numbers, 1,186 persons (including 659 males) with AIDS or advanced HIV were reported in 2006 compared with 1,344 in 2005. The number recorded for 2004 was 1,112. In interpreting the data another factor must be also taken into consideration. In July 2005, the AIDS case definition used for epidemiological update was revised to include persons with advanced HIV (that is persons with CD4[1] counts under 350).

There is also data suggesting that the gender difference may be narrowing, although AIDS case rates among men continue to exceed that among women.

[1] CD4 – One of two protein structures on the surface of a human cell that allows HIV to attach, enter, and thus infect the cell. CD4 molecules are present on CD4 cells (helper t-lymphocytes), which play an important role in fighting infections (foreign bodies).

Between January 1982 and December 2006, the cumulative number of persons reported with AIDS reached 11,739. Over the same period 6,673 persons were reported to have died from AIDS. At the end of 2005, the total number of persons reported with AIDS was 10,553.

Jamaica continues to experience a slowing down in HIV transmission with an estimated HIV prevalence rate at 1.5 per cent of the adult population. This translates to approximately 25,000 adults living with HIV and 5,000 with advanced HIV. The mean population of Jamaica is about 2.6 million with 1.4 million adults in the productive and reproductive age group of 15 to 49 years.

Approximately 70 per cent of all persons reported with AIDS in 2006 were between 20 and 49 years and 85 per cent of them fall between 20 and 60 years. This has been the trend.

In 2005, HIV was the fourth leading cause of death for all men and women in Jamaica. The main risk factors fuelling the HIV/AIDS epidemic in Jamaica are multiple sex partners, history of sexually transmitted infections, crack/cocaine use, and sex with prostitutes. As in other Caribbean islands, heterosexual transmission is the main route of transmission of HIV. However, the sexual practice of 41 per cent of reported male AIDS cases in Jamaica has been categorised as 'unknown' and many of these persons may be men who have sex with men (MSM). Among reported male AIDS cases on whom data about sexual practices are available (59 per cent of cases), homosexual or bisexual activity is reported by 14 per cent of men.

Table 1.1: Reported Risk Behaviour from 1982 to December 2006 Cumulative

Risk Behaviour	No. Persons (%)
Multiple Sexual Partners/contacts	~80%
Sex with Prostitutes	2104 (24.5)
Crack , Cocaine Use	715 (8.3)
STD History	3966 (46.1)
IV Drug Use	92 (1.1)
No Known Risk	~20%
Total (reported)	**7,927**

* Source: Ministry of Health, National HIV/STI Programme, Jamaica HIV/AIDS Epidemic Update, January to December 2006

The most urbanized parishes continue to be most affected. St. James accounts for the highest cumulative number of AIDS cases at 930 for every 100,000 persons. Kingston and St. Andrew is next in line with 665 cases per 100,000. The parishes of Manchester and St. Elizabeth have the lowest case rates with 139 and 167 cases per 100,000 persons respectively.

Sentinel surveillance indicates that there is no significant change in HIV prevalence among young people when the year 2004 is compared with 2005. Within the same period, there was also no significant change among STI clinic attendees. Among antenatal clinic (ANC) attendees the HIV prevalence registered 1.25 per cent in 2004 and 1.51 per cent in 2005. Among STI clinic attendees the HIV prevalence reached 3.75 per cent in 2004 and 4.64 per cent in 2005[2] (Tables 1.2 and 1.3).

Despite a well-established national surveillance system, collection of data in some high-risk groups remains sparse. Men who have sex with men (MSM) do not readily reveal sexual orientation due to fear of discrimination. This fear forces MSM underground leading to reduced access to prevention interventions and surveillance activities. Other populations such as commercial sex workers (CSW) are highly mobile and mapping procedures may not capture the highest risk persons in that population. For example, a 2005 second-generation surveillance of CSW in the most urbanized parishes in Jamaica showed an HIV prevalence of nine per cent. Previous surveys however have indicated HIV prevalence as high as 20 per cent in Montego Bay. [2]

Table 1.2: HIV Sero-prevalence in Pregnant Women, Jamaica, 2003, 2004 and 2005

PARISH	2003			2004			2005		
	Total tested	Total +ve	% +ve	Total tested	Total +ve	% +ve	Total tested	Total +ve	% +ve
Kingston & St. Andrew	1289	27	2.09	1214	21	1.73	1128	16	1.42
Manchester	325	4	1.23	349	3	0.86	322	6	1.86
St. Ann	472	6	1.27	313	1	0.32	290	5	1.72
St. Catherine	589	5	0.85	904	12	1.33	835	9	1.07
St. James	405	10	2.47	329	5	1.52	303	6	1.98
Westmoreland	283	4	1.41	261	0	0	240	5	2.08
Total	3363	56	1.67	3370	42	1.25	3118	47	1.51

Table 1.3: HIV Sero-prevalence in STI clinic attendees, Jamaica, 2003, 2004 and 2005

PARISH	2003			2004			2005		
	Total tested	Total +ve	% +ve	Total tested	Total +ve	% +ve	Total tested	Total +ve	% +ve
Kingston & St. Andrew	1742	98	5.63	1416	66	4.66	1361	74	5.44
Manchester	136	2	1.47	283	4	1.41	221	6	2.70
St. Ann	347	13	3.75	369	10	2.71	419	17	4.07
St. Catherine	624		1.44	630	19	3.02	600	22	3.66
St. James	536	46	8.58	356	15	4.21	520	30	5.77
Westmoreland	127	8	6.30	143	6	4.20	113	1	0.88
Total	3512	176	5.01	3197	120	3.75	3234	150	4.64

Universal Access Critical To Halt HIV Spread

The National HIV/STI Programme recognizes that universal access to prevention is critical to halt and reverse the spread of HIV. Effective prevention measures must also address the underlying social, cultural, and economic factors that impact behaviour. Despite a diverse approach to HIV prevention, recent impact studies of Knowledge Attitude Practice and Behaviour (KAPB) suggest that there has been no significant change within the past decade in high-risk behaviours of adults such as unprotected sex with a non-regular partner. While risk behaviour reached a plateau, about 77 per cent of men and 67 per cent of women on average, self report that they use a condom with a non-regular partner.

Although, general knowledge about HIV prevention is high, inaccurate perceptions about HIV transmission (such as mosquito bites) persist. This is evidenced by the fact that only 36 per cent of young men and 40 per cent of young women were able to correctly identify ways of preventing the sexual transmission of HIV and at the same time reject major misconceptions about AIDS.

A recent Multiple Indicators Cluster survey (MICS) conducted by the United Nations Children's Fund (UNICEF) shows an increase in the proportion of women who reject major myths pertaining to HIV. In the 2005 findings, most women surveyed knew that mosquitoes cannot transmit HIV and that a healthy looking person can have HIV (Table 1.4). The composite indicator of knowledge of HIV prevention and rejection of myths also showed improvement in the report. Approximately 60 per cent of women aged 15 to 49 years old were able to identify two prevention methods and reject three misconceptions in 2005 compared to 47 per cent in 2004 (Table 1.5).

Table 1.4: Percentage Of Women Aged 15-49 Years Who Correctly Identify Misconceptions About HIV/AIDS, Jamaica, 2005

	Percent who know that:			Reject two most common misconceptions and know a healthy-looking person can be infected
	HIV cannot be transmitted by supernatural means	HIV cannot be transmitted by mosquito bites	A healthy looking person can be infected	
TOTAL URBAN	94.2	83.3	96.7	77.7
KMA*	95.5	85.5	96.4	80.1
Urban	92.3	80.1	97.1	74.1
Rural	93.4	78.4	94.0	72.6

*KMA – Kingston and metropolitan St. Andrew

Since public access to ARV treatment began in September 2004, just about 2,700 or 54 per cent persons with advanced HIV have been placed on ARV treatment. Among priority objectives is increased access to testing in order to identify additional persons in need of treatment.

The PMTCT programme has been implemented in all major hospitals islandwide and has resulted in the testing of more than 90 per cent of pregnant women attending public antenatal clinics. This is confirmed by the 2005 MICS conducted by UNICEF, which found that 93 per cent of urban women and 87 per cent of rural women who were pregnant within the last two years report being tested for HIV during pregnancy. Similarly, the most recent KABP confirmed that public knowledge of PMTCT is high among women (63 per cent). [4]

Table 1.5: Knowledge of Preventing HIV Transmission and Comprehensive Knowledge, Jamaica, 2005

	Percentage who know transmission can be prevented by:			Knows all three ways	Have comprehensive knowledge (identify 2 prevention methods and 3 misconceptions) *
	Having only one faithful uninfected sex partner	Using a condom every time	Abstaining from sex		
TOTAL URBAN	81.6	90.2	88.9	68.8	59.8
KMA	79.0	88.7	86.8	64.6	58.8
Urban	85.3	92.4	92.0	74.8	61.1
Rural	86.0	86.8	84.6	68.0	57.9

It is estimated that at least 60 per cent of pregnant women access the public health system and at the end of December 2006, at least 80 per cent of HIV-

infected mothers attending public antenatal clinics received ARVs for PMTCT. Unfortunately, data on PMTCT in private sector is not readily available.

The National HIV/STI Programme (NHP) was established in 1988 as an integrated disease prevention and health promotion programme directed towards behaviour change. In 2002, the development of the National Strategic Plan on HIV/AIDS/STI (2002-2006) signified the ongoing commitment to this programme. (See Figure 3)

The year 2006 marks the end of a major phase of investment in five-priority areas: (1) policy, advocacy, legal and human rights; integrated and multisectoral response (3) prevention, (4) care treatment and support, (5) monitoring, surveillance and evaluation. During the period Jamaica has made significant strides in the five priority areas.

The achievements, the KAPB findings and multisectoral consultations conducted in 2006 have paved the way for the National Strategic Plan for 2007-2012. The new plan is based on the theme of universal access to prevention, treatment and care services. In the 2007-2012 plan, the expansion of prevention as the mainstay of the national response is the first priority. Other priority areas are (2) treatment care and support, (3) enabling environment and human rights and (4) empowerment and governance. These will guide Jamaica's response to HIV/ AIDS over the next five years.

Figure 1.3: Jamaica HIV/AIDS/STI National Strategic Plan 2002-2006: Priority Areas and Objectives

PRIORITY AREA 1 – POLICY, ADVOCACY, LEGAL AND HUMAN RIGHTS

1 To protect and promote the legal, ethical and human rights of people living with HIV/AIDS
2 To reduce human rights abuses and discrimination against PLWHA
3 To strengthen capacity of organizations to work in the area of advocacy

PRIORITY AREA 2 – MULTI-SECTORAL RESPONSE

To strengthen capacity of individual agencies sectors to respond in the following areas:

- Advocacy
- Evaluation and monitoring of strategic plan
- Public information
- Research on determinants of the epidemic
- Community involvement
- Resource mobilization to develop strategic alliances
-

PRIORITY AREA 3 – PREVENTION

1 To reduce HIV mother-to-child transmission
2 To promote and increase effective and culturally appropriate safe and healthy responsible sexual behaviour attitude and practice
3 To increase effective targeted intervention aimed at high risk behaviour and socially marginalized groups
4 To expand voluntary confidential testing and counselling
5 To reduce the incidence and prevalence of STI through effective diagnosis and treatment.
6 Condom social marketing and promotion
7 To maintain safe blood transfusion services
8 Post exposure prophylaxis

PRIORITY AREA 4 – CARE, TREATMENT AND SUPPORT

1 Increased access and improved care, treatment and support to people living with HIV/AIDS
2 Reduce the morbidity and mortality of PLWHA through implementation of a comprehensive care programme
3 Develop and expand care and support for orphans and children made vulnerable by HIV/AIDS

PRIORITY AREA 5 – SURVEILLANCE, MONITORING AND EVALUATION

1 To understand the trends of HIV/AIDS over time and the behaviour driving the epidemic and plan targeted interventions
2 To improve the quality and effectiveness of STI and HIV prevention programme

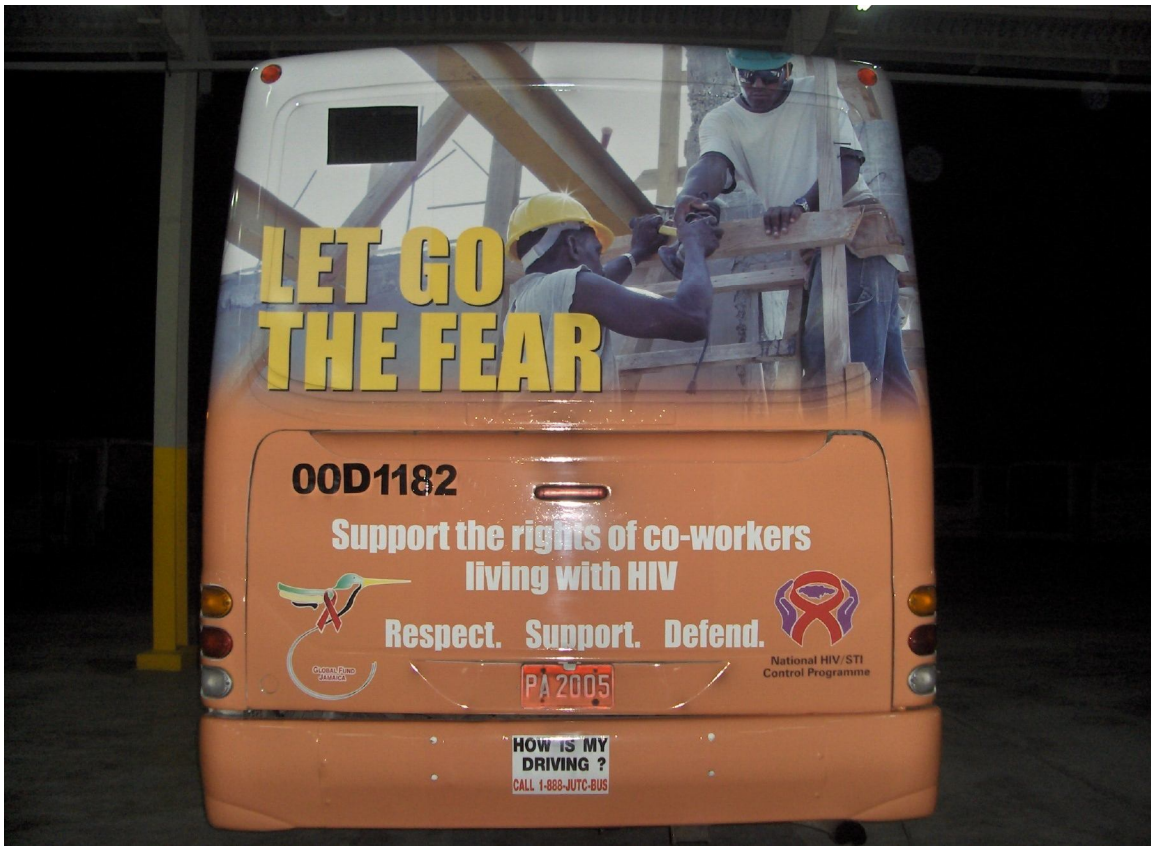
Policy, Advocacy, Legal and Human Rights

Putting not just one but a male and a female face to HIV and AIDS is the single most critical achievement in the area of policy, advocacy, legal and human rights during 2006. This bold step by Ainsley Reid and Annesha Taylor helped to dispel misconceptions about HIV and AIDS, while reinforcing the notion that "you can't tell by just looking" who has HIV or AIDS.

The faces and voices of these two Jamaicans in prime-time advertisements on television and radio for five months pushed HIV into the centre of people's households. The messages also appeared on billboards, bus-back panels and on printed materials. The 'Getting On With Life' campaign, designed by consultant, Joan Andrea Hutchinson was supported by a public relations campaign. This

increased media access and participation in existing and new interventions, ensured that Ainsley and Annesha were the positive 'talk of the town'.

The year 2006 also included messages on television and radio for the second flight of the 'Defend This' campaign. This campaign was designed by Dunlop Corbin Communications. Messages were targeted to the adult population at the workplace (15-49 years) asking them to let go the fear and support workers living with HIV. Messages on billboards and busback panels ran until November 2006. The campaign featured two 20-second TV, radio spots, a 15-segment radio drama and messages on posters.



The development of appropriate policies with supportive legislation are required to protect the rights of all Jamaicans including the marginalized and persons living with and affected by HIV and AIDS. The approval of the National HIV/AIDS Policy in 2005 and the continuing lobbying for the approval of the National HIV/AIDS Workplace Policy during 2006 laid the foundation for development of HIV/AIDS workplace policies and programmes within public and private sector organisations.

During 2006, stakeholders were given technical and financial resources to deal with HIV/AIDS at the workplace. All policies use the 10 principles of the ILO Code of Practice on HIV/AIDS in the world of work, as the main tool to achieve non-discrimination and protection of rights in the workplace. These 10 principles are

part of the National HIV/AIDS Policy and the draft National HIV/AIDS Workplace Policy. The issues surrounding policy, advocacy legal and human rights were managed primarily through the policy/advocacy component of the National HIV/STI Programme (NHP) and through the National AIDS Committee (NHP). The NAC received financing as a sub recipient of the Global Fund grant to scale up treatment, prevention and policy efforts.

The main objectives of the policy/advocacy component are (1) to improve the rights of persons living with and affected by HIV/AIDS by developing a comprehensive policy framework; and (2) to reduce stigma and discrimination to PLWHA and those affected through advocacy and public education.

Under the Global Fund grant the policy/advocacy component was initiated in 2004 to expand the number of (1) organizations adopting workplace policies and not supporting HIV screening for exclusion and (2) the number of cases of stigma and discrimination reported by institutions. This component enabled the National HIV/STI Programme (NHP) and the National AIDS Committee (NAC) to expand workplace initiatives since 2004 beyond the health sector and the five sector ministries to other government ministries and to more private sector organizations.

Private Sector Support

The highlight of 2006 for the private sector was the inauguration of the Jamaica Business Council on HIV/AIDS (JABCHA) during an official ceremony on September 26, 2007.

Business tycoons support HIV/AIDS through the Jamaica Business Council on HIV/AIDS (JABCHA) formed on September 26, 2006

On that occasion, 21 leading business tycoons in Jamaica pledged their individual and company support to expand the business response to HIV/AIDS in

Jamaica. This 21-member group broadened the reach to the private sector numerically and elevated the response to involve a new cadre of high-level leaders.

Two sub recipients, of the Global Fund grant, the Jamaica Employers Federation (JEF) and the National AIDS Committee (NAC) were given the mandate to each reach 40 large private sector companies (> 100 employees). All 40 companies were expected to development an HIV/AIDS workplace policy and a year's implementation plan under the guidance of company focal points on HIV/AIDS and a steering committee.

Under the policy/advocacy component, the Jamaica Employers Federation (JEF) courted 40 private sector companies and provided technical assistance, which led to the establishment of HIV/AIDS workplace programmes. Policies were drafted by 27 companies and 32 persons were trained as trainers. The federation further secured commitments from 26 chief executive officers (CEOs) to ensure engagement of their respective organisations in the national HIV/AIDS response.

During 2006, JEF as a Global Fund grant sub recipient agreed to expand this pool of 40 by 20 and to hire an Occupational Health and Safety (OSH) Executive and second this officer to the programme to coordinate its HIV/AIDS response. The Jamaica Employers Federation however did not expand its pool of companies, as it couldn't sustain the right kind of person to fill the OSH executive position. This affected this sub recipient's capacity to meet the requirements under the Memorandum of Understanding which it signed during the period.

The National AIDS Committee in its bid to identify and train high-level leaders as HIV/AIDS advocates, lobbied chief executive officers in breakfast meetings and obtained 19 commitment signatures. The policy/advocacy component placed a Workplace Policy Facilitator in the NAC Secretariat during November to help coordinate workplace policy and programme development and implementation among 40 companies. Up to 2006, the NAC had eight companies on its list with HIV/AIDS workplace policies.

During 2006, the ILO/USDOL Education Workplace Programme inaugurated in 2004, continued its work among 15 enterprises, with five of them developing draft workplace policies and trainers in all enterprises being identified and trained.

Public Sector Support

After a period of negotiation, four public sector ministries agreed to become sub recipients through a secondment process. All government ministries are required to have HIV/AIDS workplace policies and programmes under a mandate approved by Cabinet in 2002. The process began with the five sector ministries.

In 2004, other government ministries were invited to nominate a Focal Point on HIV/AIDS who would coordinate HIV/AIDS workplace interventions. During 2006, steps were put in place to move from employing external consultants to help guide the process and recruit existing staff from the participating ministries.

By the end of 2006, all government ministries had at least nominated and confirmed a Focal Point on HIV/AIDS and developed a draft workplace policy. Other ministries were rolled into the programme from June 2004.

These ministries further established respective steering committees and produced a draft annual work plan for the integration of HIV/AIDS. The process involved sensitisation and training through seminars and workshops. These sessions were participatory and engaged the attendees in interacting knowingly with a person living with HIV and AIDS (PLWHA), exploring sexuality, values clarification and risk reduction and non discrimination issues.

By the end of the 2006 two Workplace Programme Officers were confirmed and seconded from the Ministry of Agriculture and Lands and the Ministry of Housing Transport Water and Works respectively, to coordinate the workplace implementation programme. Other ministries - Industry Technology Energy and Commerce, Finance and Planning, Office the Prime Minister/Cabinet Office, Justice, Foreign Affairs and Foreign Trade - supported the idea of the secondment approach and agreed to participate by early 2007.

The policy/advocacy component also provided technical assistance to the core sector ministries on request concerning revision and approval of their workplace policies.

Technical assistance was given to the Ministry of Health through its human resources and manpower planning division to integrate HIV/AIDS workplace issues into operational plans. Sensitisation workshops were conducted among 120 members of staff at headquarters (from senior directors to ancillary staff). A Focal Point on HIV/AIDS within the Ministry of Health was identified.

Greater Involvement of Persons Living With HIV and AIDS

HIV-related discrimination affects the capacity of persons living with HIV and AIDS (PLWHA) to disclose status or to be identified. During 2006, PLWHA continued to get involved in face-to-face interventions in schools, worksites, churches and other non-governmental organisations. There was further integration of PLWHA into workplace sensitisation and training programmes and on advisory committees. Each participant was able to access a small stipend by submitting a simple claim form with evidence of the type of participation attached.

The Jamaican Network of Seropositives (JN Plus) also signed a Memorandum of Understanding with the NHP to assist in the capturing of reports of acts of discrimination among other things. This led to the creation of a national advisory group on discrimination reporting and redress led by the Advocacy Officer of JN Plus. The Board and Secretariat had signed off on a new Memorandum of Understanding (MOU) during October that explained JN Plus' work plan and commitment as a sub recipient of the Global Fund for the period June 2006 to May 2007. JN Plus had completed its responsibilities under the previous MOU ending in May 2006.

At the end of 2006, the Secretariat was employing 1 Executive Director, 1 Programme Officer, 1 Advocacy Officer, 2 Outreach Officers and 1 Accounting Officer. With the exception of the Advocacy Officer, the entire staff consisted of persons recruited between September and October 2006.

At the end of 2006, there were 91 new members documented by the Jamaican Network of Seropositives (JN Plus). The records also showed two new self-support groups among eight active ones (meetings held regularly). The network also held four regional meetings with 109 members participating.

There were 162 JN Plus members who were involved in the national response by their participation in interventions within workplace settings in the public and private sectors and non-governmental organizations. This was assessed from the number of stipend claim forms approved.

Ten persons living with HIV including eight JN Plus members completed a five-day training programme in advocacy and communications facilitated by the Caribbean Institute of Media and Communications (CARIMAC) and sponsored by the Global Fund. The programme was conducted on site at CARIMAC giving the participants hands-on relationship with multi-media studio equipment.

Reports of HIV-Related Discrimination

Just about 33 HIV-related stigma and discrimination reports were captured in a preliminary database. Under the guidance of the Advocacy Officer, two forms were created to gather HIV-related stigma and discrimination complaints. JN Plus members received opportunities for improved knowledge of advocacy with 100 of them being sensitised and trained in how to advocate on stigma and discrimination issues.

PLWHA Website Launched

After a year of preparation assisted by a local website consultant, the Jamaican Network of Seropositives launched its website for a trial period during 2006.

Staff Attrition

The high turnover of JN+ Secretariat staff affected implementation of activities. In addition, the Board-Secretariat relationship affected the stability and cohesiveness of operations. PLWHA on staff and others need assistance to address low-literacy and self-support mechanisms. These issues will be placed on the agenda for 2007.

Legislative Support

Preliminary steps were also established towards supportive legislation and policy interpretation with the assistance of the National AIDS Committee, the Planning Institute of Jamaica (PIOJ) and the UN Theme Group on HIV/AIDS in Jamaica among others. This led to the formation of an advisory group on policy legislative matters chaired by the PIOJ, which met two times during 2006.

The National HIV/STI Programme through the policy/advocacy component commissioned legal consultants to review the existing legislative framework and make recommendations. Such recommendations would form the basis for recommendations to Cabinet to address legislative gaps related to HIV/AIDS. The firm McNeil and McFarlane was retained and guided by an advisory committee consisting of representatives from UNAIDS, the Attorney General's Office, NHP and NAC.

The McNeil/McFarlane report recommended two legislative options (1) a non-discriminatory legislative framework which takes PLWHA into account or (2) the introduction of HIV/AIDS specific legislation.

Option 1 would require repeal and reformulation of laws including review of definitions to ensure that PLWHA human rights are protected. This would require the repeal of laws which are no longer useful and involved quarantine such as the Leprosy Act, the Venereal Diseases Act and the Quarantine Act. Under this option, other laws requiring amendment would be (1) the Public Health Act and regulations (2) the National Insurance Act (3) the Pensions Act (4) the Alien Act (5) the Immigration Restriction (Commonwealth citizen) Act (6) the employment (Termination and Redundancy Payments) Act and (7) the Education Act and Regulations

Option 2 recommended the introduction of HIV/AIDS specific legislation to provide a supportive environment provided it is conducted in a way that may not seem discriminatory of those, which it seeks to protect.

High Level Leadership Advocacy

Parliamentarians: The National AIDS Committee (NAC) under its MOU with the NHP facilitated the signing of a declaration of commitment by 19 political

representatives signalling their participation in the national response as HIV/AIDS leadership advocates. The first 10 commitments were received immediately following a one-day sensitisation workshop. The target group comprised of parliamentarians, senators, ministers-of-state, mayors, deputy mayors and executive members of youth organisations affiliated with the major political parties. Follow-up interventions resulted in an additional nine commitments.

Meetings were also held with local government representatives, notably the Kingston and St. Andrew Parish Council (KSAC) and the St. James Parish Council. Both councils passed a resolution to recognise HIV/AIDS as an issue affecting the city and indicated their intention to take effective action to reduce the spread of HIV in the parishes of Kingston & St Andrew and St. James. Two councillors were appointed to act as Focal Points on HIV/AIDS within KSAC and the former Mayor of St. James, Councillor Solomon was appointed to at as Focal Point on HIV/AIDS for St. James. The Deputy Mayor for Montego Bay participated in the City AIDS Conference held in Atlanta in May 2006 and made commitments at that event to implement HIV/AIDS programmes within the St. James Parish Council.

Civic Representatives: Following a World AIDS Day (December 1, 2006) breakfast meeting, 26 civic representatives signed a declaration of commitment. These persons were religious leaders, educators, private sector representatives, senior public servants and members of the diplomatic corp.

While commitments were received from political and civic representatives, no steps were taken within the year regarding implementation.

Legal Fraternity: A slew of 19 lawyers signed commitments as HIV/AIDS leadership advocates. Those in the public and private sectors tendered declaration of commitment to advocate against HIV-related stigma and discrimination and to become members of the Legal and Ethical sub committee of the National AIDS Committee. Private sector lawyers also indicated their intention to provide *pro bono* legal services to persons living with HIV.

During the year, selected lawyers acted in court proceedings on behalf of a member of the Jamaican Network of Seropositives who was charged with unlawful wounding after being evicted by the landlord allegedly based on knowledge of HIV status. Three lawyers also reviewed the case for students denied entry to school in Montego Bay in 2004 on the basis of being affected by HIV. The lawyers have advised that no action can be brought against the school because the school is a private entity. The guardian of the students was advised to pursue action for breach of contract. A working group looked at the National Policy for HIV/AIDS Management in Schools and the Education Act and noted that based on the classification of HIV as a “communicable” disease, it was difficult to rule as unlawful, any attempt to deny students access to school. This

led to the need to recommend amendment to the Education Act and further support for amendment to the Public Health Act.

During the reporting period, the Legal and Ethical sub committee reviewed the proposed Charter of Rights, advising that it was deficient insofar as it didn't guarantee the right to health care and the right to freedom from discrimination due to health status or because of disability. The related Parliamentary Submission was delivered on June 21, 2006.

It is clear that there is much ground left to cover. The need to lobby, advocate and contribute to the preparation of Cabinet submissions regarding amendment to existing legislation, namely the Education Act and the Public Health Act, to support the National Policy for the Management of HIV/AIDS in Schools is more evident than ever. Improved access to health and prevention services within prison systems is also another matter that must be high on the agenda.

Chief Executive Officers: The strategy used was to use umbrella groups to reach CEOs and other senior directors. The organizations that were involved included the Jamaica Exporters Association, Private Sector Organisation of Jamaica, Jamaica Manufacturers Association and the Chambers of Commerce. Meetings were held with parish-based Chambers of Commerce in St. Ann, Westmoreland and Portland. Executives of these organisations agreed to work with the NAC in implementing HIV/AIDS education workplace programmes.

Twenty-one participants from a target of 30 were part of a "Champions for Change" workshop. Up to the end of December 2006, no follow-up meetings were conducted. These meetings along with sensitisation workshops were planned and are to be implemented in 2007.

Study Tour: Four HIV/AIDS Leadership Advocates joined a representative from the National AIDS Committee and the National HIV/STI Programme in a study tour of selected programmes and places in Bangkok, Thailand. Participants were (private sector) Lascelles Chin; (public sector) Michael Muirhead (Tourism) and Neville Moodie (Labour and Social Security); (political directorate), Dr. Andrew Wheatley (Mayor, Spanish Town), Vivian Gray (NAC) and Novia Condell (NHP).

Trade Unions

The NHP through the policy/advocacy component hired a short-term consultant to coordinate sensitisation and training among trade union delegates. Approximately 120 union delegates were sensitised and 80 trained as workplace advocates during a series of workshops held in four regions designated by the Jamaica Confederation of Trade Unions (JCTU).

Schools and HIV/AIDS Policy Issues

The Bank of Nova Scotia launched a debating competition for students from 200 primary schools during December 2006. Scotiabank began its support of HIV/AIDS issues in Jamaica earlier in 2006 when it donated an award to the national debating competition among high school students.

HIV/AIDS policy issues in schools were promoted during March to April 2006 through a debate focusing on the National Policy for HIV/AIDS Management in Schools.

Cornwall College hailing from St. James trumped Charlemont High School from St. Ann in the finals of the National Debating Competition held at the Hilton Hotel on April 26, 2006. Charlemont received the next best position of first runner-up in a contest launched officially on March 10 by the Minister of State, Dr. Donald Rhodd.

Some 37 schools in the six regions designated by the education ministry were approved to contest the debate. The competition provided an opportunity for students and teachers to engage in dialogue and research on HIV/AIDS policy issues. The event was organised by the policy/advocacy component of the National HIV/STI Programme in collaboration with the Ministry of Education and Youth. Under the policy/advocacy component, a steering committee led by a short-term consultant coordinated the implementation of the competition. The team produced and implemented a competition manual including guidelines for participants and adjudicators. The Global Fund, USAID/JA-Style Project and the Bank of Nova Scotia provided trophies and other prizes.

Drug Abuse and HIV

The policy/advocacy component hired a short-term consultant for six months to help identify some links between HIV/AIDS and drug abuse and chart the way forward through the creation of policy guidelines. This undertaking was in cooperation with the National Council on Drug Abuse (NDAC). The consultant engaged the participation of stakeholder groups in St. James, St. Ann and Kingston and St. Andrew. However, the pulling together of the findings and the recommendations did not meet the expectations of the adhoc advisory committee representing the NHP and the NDAC. The NHP considered support of a programme officer to assist the NDAC in assessing and planning for risk reduction among persons addicted to illegal drugs and living with HIV.

Faith-Based Organisations

The Caribbean Conference of Churches (CCC) employed a person living with HIV – Ainsley Reid - as its Programme Officer to coordinate HIV/AIDS interventions. The policy/advocacy component maintained links with the CCC

through the programme officer for collaboration in policy development among faith-based organisations. Further interventions are scheduled for the period 2007 to 2008.

Through this office of the Programme Officer and with support from the Canadian International Development Agency (CIDA), the CCC developed a regional policy and plan of action for dealing with HIV/AIDS in faith-based organisations (FBOs). The CCC designed, produced and disseminated 1000 copies of the policy guidelines. The organisation also conducted workshops among clergy and laity of FBOs and their umbrella groups in Jamaica, Belize and Bahamas.

During 2006, the CCC conducted 20 awareness sessions involving selected congregations and sensitised 150 women leaders to HIV/AIDS issues, gender sensitivity and discrimination reduction. The women were drawn from Manchester, St. Ann, Kingston and St. Andrew and St. James.

Support material

The workplace and policy interventions were enhanced by the development and use of a docu-drama produced on DVD and videotape. Four hundred of 500 copies were distributed. An amount of 2500 National HIV/AIDS Policy documents and 2100 summary policy booklets were printed with 2000 of each distributed.

Way Forward

Workplace Programme: Interventions should lead to the integration of HIV/AIDS into the operational plans of public and private sector entities. Negotiations should be conducted to involve additional umbrella group participating in the coordination of workplace policy and programme development and implementation within the private sector.

Sub Recipients:

PLWHA/JN Plus: The high turnover of JN+ Secretariat staff affected implementation of activities. In addition, the Board-Secretariat relationship affected the stability and cohesiveness of operations. The JN Plus Board must hold its annual general meeting during 2007, revise its constitution and ensure that the organisation is a viable and legal entity in relation to local and company laws.

PLWHA on staff and others need assistance to address low-literacy and self-support mechanisms. The JN Plus work plan should include opportunities for training and education to develop literacy and self support skills

NAC: The NAC was successful in garnering commitments from high level leaders signalling their participation as leadership advocates. However, no steps were

taken within the year regarding implementation. Staff attrition and sustainability issues also affected other expected outputs from the NAC. As a result the high-level advocacy programme did not continue with its gusto debut. This entity needs additional staff to help it separate administrative/financial and programme development interventions.

JEF: This entity has to demonstrate during 2007 its capacity to submit deliverables in relation to its work plan and target audience

Legislative Support: A dedicated Human Rights (Legal) Officer should be hired to coordinate the process of moving policy into parliamentary accord for legislative support.

Trade Unions: Worker representative participation should be promoted within all workplace programmes. Trade union delegates trained as 'trainers' should be certificated following opportunities to engage in training interventions.

Faith-Based Organisations: The Caribbean Conference of Churches (CCC) and the policy component will work closely during 2007/2008 to expand policy development and implementation among faith based groups with an emphasis on non discrimination.

Drug Abuse and HIV: The NHP is considering support of a programme officer to assist the NDAC in assessing and planning for risk reduction among persons addicted to illegal drugs and living with HIV.

Support Material: By 2009, training manuals on HIV/AIDS workplace policy implementation will be developed and disseminated to constituents in the public and private sectors.

Mass Media: The policy component will continue to liaise with the prevention component concerning appropriate development and placement of mass media and outdoor advertising campaigns.

Schools: This component will deploy a full-time Youth Coordinator to deal with non discrimination in schools

Prevention

Acts of discrimination to children and adolescents living with or affected by HIV will undermine prevention efforts and feed resistance to such efforts. The prevention team therefore lauds the efforts of one of its stakeholders – the Ministry of Education - in addressing and seeking redress for 20 HIV positive students who faced discrimination within the school environment. In the meantime, the Education ministry was engaged in revising one of its critical curriculum guides under its Health and Family Life (HFLE) curriculum to ensure that HIV/AIDS issues are addressed.

National celebrities such as Miss Jamaica Universe; Miss Jamaica World and the world's fastest 100 metre sprinter participated in national activities by getting tested for HIV. National activities are intended to improve awareness and complete existing interventions.

Prevention officers also implemented cutting edge activity[2] in the form of a randomised control trial (RCT) in the Kingston and St. Andrew region in about 50 clusters to influence risk reduction behaviour change.

The prevention team entered the year 2006 being fully aware of some specific challenges facing the component. Findings from the 2004 Knowledge Attitude Practice and Behaviour (KAPB) survey, follow-up meetings and discussions focussed on analysing the behavioural plateau in risk behaviours since 1996.

The team worked with meagre resources on planned interventions knowing that a ten-fold scale in coverage was needed to impact the present epidemic. Strategies had to be targeted to those most-at-risk catering to their personal risk behaviour within the context of the social and economic conditions that increase one's vulnerabilities.

Within this scenario, three main priorities were identified:

i) Institutionalising HIV/AIDS into the formal education sector
ii) The implementation of PLACE random control trial in KSA and the subsequent roll out of the intervention strategies to the Regional Health Authorities RHAs) and
iii) Targeted interventions to reach the vulnerable populations of sex workers, men who have sex with men and sexually active adolescents

[2] **PLACE – Priority for Local AIDS Control Efforts** method is implemented in five steps that systematically identify areas where HIV incidence may be high, characterise and map sites in those areas where interventions should be focused, and provide feedback to communities for intervention planning.

Other areas of focus included: building the capacity of the prevention team within the regional health authorities (RHAs) and also the non governmental organisation (NGO) sector, the production and placement of media campaigns and development of other educational support materials to reinforce interventions.

The interventions were especially designed to contribute to particular programme indicators and as such there was the need to develop specific tools to strengthen the monitoring and evaluation capability of the team. The details of the achievements in each priority area are outlined below:

Priority 1: Institutionalising HIV/AIDS into the Formal Education Sector

The prevention team collaborated with the Ministry of Education and Youth under a Memorandum of Understanding, which recognised the ministry as a sub recipient of the Global Fund grant to scale up treatment prevention and policy efforts. The main task was to expand the Health and Family Life Education (HFLE) curriculum and integrate it into the training material for teachers' colleges through the Joint Board of Teacher Education (JBTE). The revised curriculum was piloted in selected teachers' colleges. The mission of the JBTE is to ensure quality and excellence in teacher education, through autonomous action in determining the curriculum, the examinations, and the process of award of teaching credentials in the Bahamas, Belize and Jamaica.

The implementation of the revised curriculum for Grades 6-11 was piloted in 24 schools. Five health promotion officers supported by the NHP facilitated this project. The number of Health Promotion Officers was reduced to three in the last quarter of 2006. An assessment of the pilot project will be used to further inform the revision process. A follow-up phase is scheduled for early 2007.

This project for HFLE/ HIV and AIDS education in Jamaica was set up as part of the national initiative to integrate HIV/AIDS into existing curricula and assess its delivery. The project incorporates the following areas:

1. The development and implementation of (i) a two-credit HFLE/HIV AIDS course for incorporation into the Personal Development programme of the teachers colleges (ii) an elective HFLE course and (iii) infusion of HIV and AIDS concepts and methodology into three selected courses. All are aimed at assisting with the preparation of young teachers to teach HFLE in schools
2. Development of handbooks and other teaching/learning resources to support the curriculum
3. The development of networks within the colleges and between the colleges and their communities
4. Research on HFLE/HIV AIDS education.
5. The development of HFLE HIV AIDS initiatives within the colleges.

A curriculum for the early childhood level was also developed with the pilot phase scheduled for early 2007.

Priority 2: Randomised Control Trial in KSA and Health Regions

Under the Priorities for Local AIDS Control Efforts[3] (PLACE), a randomised control trial (RCT) was initiated in the Kingston and St. Andrew (KSA) area in January 2006. The PLACE study preceding the RCT identified 146 sites where people 'meet new sex partners'. These 146 sites were randomised into 50 clusters. Of the sites, 72 were categorised as controls and 74 earmarked as intervention sites. All sites were then subdivided into three (3) categories as shown in the table below.

Table 3.1: Distribution of PLACE Sites

Type of Sites	Number of Sites	
	Intervention	Control
Bars/clubs/ hotels	15	13
Sex on street	11	16
Outdoor socializing	48	43
Total	**74**	**72**

The PLACE baseline research data on the sexual attitudes and practice of patrons socializing at sites in the study showed similar trends to the national KAPB (2004) survey. Condom use was already relatively high. Reported non-risky sexual behaviour at the intervention sites was 72.4 per cent while at control sites it was 74.4 per cent. New partner acquisition in the last year, based on a sample size of 2507, was 55.36 per cent at the intervention sites and 51.85 per cent at control sites.

A major challenge however was to conduct activities which facilitate an increase in non-risky sexual behaviour at intervention sites. The close geographic proximity of all sites resulted in mixing of patrons from control and intervention sites. A post-intervention evaluative research was commenced in November 2006 to end in January 2007. Qualitative and biostatical data were collected to allow comparison between people socialising at different sites.

The intervention activities were carried out for nine non-consecutive months and had the following four phases:

[3] **PLACE – Priority for Local AIDS Control Efforts** method is implemented in five steps that systematically identify areas where HIV incidence may be high, characterise and map sites in those areas where interventions should be focused, and provide feedback to communities for intervention planning.

- Phase 1: Observation of site and environs for generation of baseline information.
- Phase 2: Solicit support and proactive partnership with gatekeepers of intervention sites.
- Phase 3: Building a healthy environment.
- Phase 4: Monitoring activities of the peer educators and "influentials" at the site and development of a sustainable intervention plan.

The evaluation of the RCT was scheduled for completion in 2007. During the period 6,880 persons were tested using the Rapid HIV test. During July 2006 the final month of the intervention 25,036 women and 24,311 men were engaged in risk reduction interactions with members of the outreach workers. Additionally, 170 contacts were made with sex workers.

The PLACE intervention strategy commenced in three of four regional health authorities (RHAs) in 2006. Teams were trained in the various strategies by a PLACE coordinator and field supervisors. The training included a practical component that comprises a hype session and voluntary testing and counselling (VCT) using the rapid test. Since the training three regional health authorities have implemented interventions at several locations. These include May Pen in the South, Ocho Rios in the North East region and Montego Bay in the West.

Priority 3: Targeted Interventions for Vulnerable Populations

The interventions targeting vulnerable populations were conducted at the field level by regional staff. The goal was to increase outreach activities, and teams in the regions were expanded to include Targeted Intervention Officers as well as increased numbers of Community Peer Educators.

Men Who Have Sex with Men (MSM)

Trained peer educators from the community of men who have sex with men (MSM) allowed the NHP to reach MSM during 'lymes' conducted at popular spots. This has contributed to the increased number of interventions targeting MSM during 2006. However, not all regions were able to develop sustainable interventions. The southern and northeast regions were more successful and were able to conduct interventions in safe spaces for this population. The prevention teams within regional health authorities (RHAs) identified peer educators. Their main task was to promote condom use, reinforce condom use skills, and encourage voluntary testing and counselling and facilitate HIV testing using the rapid test.

Sex Workers

Outreach activities to the population of commercial sex workers (CSW) were increased in all health regions. These interventions included risk reduction conversations with the sex workers, their clients and patrons; increasing condom access; building condom use and condom negotiation skills; training of peer educators; providing on site testing for HIV; securing the commitment of the club operators and creating a safer sex environment. The recruitment of seven targeted intervention officers was identified as the primary stimulus for increased activities. However, implementation was not carried out in a uniformed manner across the regions.

The main challenges experienced were related to the highly mobile nature of the sex workers that was both intra-parish and inter-parish. Local community peer educators (CPEs) had difficulties achieving repeat contacts with them. The major behavioural issue in this population that requires attention is inconsistent condom use with main partners. It is believed that building self-efficacy may enhance condom negotiation skills.

(Table3.2 showing regional # sex workers reached and trained, condoms outlets established condoms distributed)

Youth/Adolescents Interventions

In recognition of the increased involvement of youth in the national response, the prevention team recruited a youth intervention coordinator in the final quarter of 2006. The primary responsibility of this officer was to mobilize young people in and out of school and provide avenues for their involvement in the design and roll out of prevention programme and strategies geared for young people.

School Interventions: The coordinator and two members of the prevention team conducted interventions in schools and also participated in the fortnightly "Radiocation" programme broadcast by a popular media house. This programme mixes education with entertainment and is broadcast live from different schools nation wide. Involvement in this activity allowed the team to interact with approximately 50,000 students at six different schools. The coordinator also developed a strategy for "abstinence" and an "abstinence-plus" programme to be implemented in selected schools.

Summer Youth Camps: During July 2006, eight summer camps targeting adolescents between 12 and 18 years were implemented. The objectives were to promote delaying sex and consistent condom use among target population; encourage and reinforce accurate risk assessment for HIV/STI infection. This

intervention reached approximately 80 adolescents within the target age group from both urban and rural participants.

Adolescents reported that practicing abstinence was difficult. The following is a summary of their views:

> Not only was it difficult to control their own urges but there was also overwhelming pressure to have sex from music, media and peers. Both male and female campers generally believed that males should have sex earlier than females. It was suggested that boys should start between 12 and 14 years old and girls should wait until 16. It was also a common belief that boys should establish that they are not homosexual by engaging in sex from as young as 10 years old. Of interest, youth in the rural groups appeared to be more resilient to pressure to have sex than the urban youth.

Party interventions: One coordinator conducted a three-month intervention at popular parties with 10 team members ranging from ages 18 –24 years old. The main objectives were to increase condom access at these sites, build condom-use skills as well as make referrals for HIV rapid test and STI checks. The main strategies included maintaining a visible presence of the condom through games, giveaways, condom demonstrations, strategic placement of posters promoting condom use and abstinence messages; conducting evaluation of administered questionnaires on sexual behaviour and condom usage and patterns of adolescent and young adults attending intervention events; conducting focus group discussions and in-depth interview of participants and key stakeholders in the entertainment industry to further strengthen and establish sustainability of the intervention; developing a public relations campaign to promote the intervention via talk shows and print media focusing on youth.

The team attended 15 events and interacted with an approximately 4,500 persons. They administered 864 behavioural questionnaires, distributed 4,500 risk cards and engaged 968 patrons in condom demonstrations. In general more males were involved in the condom skills building activities. This observation is inconsistent with that of other prevention activities as usually females are more receptive.

Table 3.3 summarizes the risky sexual behaviours that were identified amongst the patrons. Approximately 40 per cent of persons admitted to having multiple partners. Of interest, 91.5 per cent of these persons were male. These individuals with multiple partners were then prompted to say if they used condoms with their partners; less than 30 per cent of these persons did. Approximately one in four persons had a new sexual partner in the last two to three months.

Table 3.3: Risky Sexual Behaviour of Party Patrons in 2007

Risky Behaviour	Yes
Multiple partners	42.4% (91.5% M/ 8.5% F)
Condom use with Multiple Partners	28.2%
New partners in last 2-3 months	26%

Peer Education Strategy. Peer education training and sensitisation programmes were conducted among students in the western region. HIV/AIDS sensitisation and interaction programmes, which included the abstinence message, were conducted among students in primary, junior high and high schools in all four parishes. Strategies such as role-play, drama and viewing of displays were used in these groups. Students from 12 schools in the region were reached via the peer education and other strategies.

In the parish of Westmoreland, an adolescent friendly centre was established, where students have appropriate access to clinic services and counselling provided by teen friendly practitioners.

Other Areas of Focus

Condom Social Marketing: During 2006, formal agreements were made with two major distributors and a gentleman's agreement with three others to increase the availability of brand name condoms across the island. The total number of non-traditional condom outlets established by the regions was 148. This number exceeded the target of 120. Thirty community based youth friendly condom distributors were also established. To ensure sustainability of these non-traditional outlets, three sub-distributors were trained to perform monitoring activities.

Additionally, over 12,500 packs or 36,000 individual condoms were distributed and just fewer than 1,200 posters and other information encouraging condom use were disseminated. Other activities that were investigated included expanding the number of condom dispensers in tertiary educational institutions and also the possibility utilizing the enclosures of Automated Banking Machine to house dispensers thus realizing the desire to have 'condoms available at every turn'.

Targeted Community Interventions: These six-month long activities target high-prevalence, usually low-income communities. They are coordinated at the regional level by the Targeted Intervention or BCC Officer, community leaders and the community peer educator. The interventions involve:

- Peer to peer education
- Increasing access to rapid HIV testing
- Referral for STI check and treatment

- Increasing condom access
- Training of peer educators within the community

In an effort to change the physical environment, messages are posted strategically within the community. Approximately 25 communities were engaged in interventions during January to December 2006.

(Table showing intervention in regions, condom outlets persons reached, persons tested)

Community Walks. Community peer educators also conduct 'community walks' which are of shorter duration and less labour intensive than the TCIs. The aim of this intervention is to engage community members in risk reduction conversations and activities to build condom use skills.

(Table showing Persons reached by region, sex, and age)

Sector & Community HIV Prevention Response

The Sector & Community Response comprises five public sector ministries (Line Ministries) entrusted with technical and financial assistance since 2002 to maintain an HIV/AIDS sector programme among their staff and constituents:

- Ministry of Local Government & Environment
- Ministry of Labour & Social Security
- Ministry of National Security
- Ministry of Education and Youth
- Ministry of Tourism, Entertainment & Culture

These partnerships were forged to implement the requisite multi-sectoral response to the national HIV epidemic indicated in Jamaica's HIV/AIDS/STI National Strategic Plan 2002-2006. The main objective of the HIV/AIDS sector response programme is to reduce the incidence of new HIV infection through improved knowledge about HIV/AIDS and access to preventive measure leading to behaviour change. Principal attention is given to workplace populations and communities associated with the line ministries.

Ministry of Local Government and Environment (MLG & E): Formerly under the Local Government, Community Development & Sport portfolio, there was a replacement of five agencies in this ministry. The overall effects of these changes on the sectoral response were the need to engage the new entities in issues related to HIV prevention and the resultant revision of the policy guidelines to include the environmental agencies.

The main achievements of the MLG & E in 2006 included the engagement of a majority of its sectoral publics in HIV prevention. These included persons affiliated with: the Infirmaries, the Women's Centre of Jamaica Foundation, the Parish Councils and the Parish Development Committees and youth in sports among others.

This ministry also printed its HIV/AIDS Workplace Policy and trained 964 persons in various areas of HIV prevention. A critical step in ensuring sustainability of the sectoral response was achieved with the appointment and training of 23 sub-Focal Points to lead the sectoral response at the agency level. Additionally, they also established HIV/AIDS corners at regional offices and institutionalised an electronic monthly newsletter on HIV prevention. Seven condom vending machines were acquired and installed at the Women's Centre Offices in Kingston, Spanish Town, St. Ann, Montego Bay, Mandeville, Savanna–la-mar and Port Antonio.

The MLG & E cited a number of important lessons learned in 2006, among them the need to engage the political directorate and managerial staff in the sectoral response. This sector is moving towards maintaining a competent cadre of peer educators at the regional level, supplying low literacy materials for some of their publics and expanding the level of inter agency and intra agency participation.

Ministry of Labour and Social Security (MLSS): The Ministry of Labour has led the way in the development of the National HIV/AIDS Workplace Policy that has been a draft document since 2003. In its current state, it has been used to guide other stakeholders. It is expected that Cabinet and Parliament would approve this national policy in 2007. This ministry is also looking at expanding its reach to build the capacity of its labour officers and inspectors to facilitate the implementation of the National HIV/AIDS Workplace Policy.

A major achievement during 2006 was the incorporation of on-site HIV testing with mass public sensitisation interventions and the commencement of a national survey on the impact of HIV/AIDS in the Jamaican workplace in November 2006. Findings of this survey should be revealed in 2007.

The Ministry of Labour and Social Security (MLSS) was initially given the mandate to integrate responses to HIV/AIDS across its agencies. The ministry conducted a number of workshops and training sessions to ensure that a cadre of competent persons was maintained to continue the HIV prevention sectoral programmes. The main achievements of the MLSS in 2006 were improved engagement of vulnerable populations, such as migrant workers, through targeted interventions and the training of 50 staff members in Voluntary Counselling and Testing. The training intervention includes PATH officers; persons involved in overseas employment office and parish officers among others.

Over 800 persons were sensitised and training in various areas of HIV prevention during 21 workshops. The ministry also acquired and placed four condom

vending machines and procured 1000 units of female condoms. The MLSS plans to annually upgrade the skills of its peer facilitators and maintain a roster of persons trained in Voluntary Counselling and Testing to support its interventions, especially at the Overseas Employment Division.

Ministry of National Security (MNS): The context of responding to HIV/AIDS created an opportunity for the Ministry of National Security to use the skills and talents of inmates in prevention education. Sixty gold medals were awarded to inmates for cultural items submitted to the annual national arts festival coordinated by the Jamaica Cultural Development Commission. The participating inmates also earned 58 silver medals and 49 bronze medals. All entries were developed around a HIV prevention theme.

The Ministry of National Security also fielded the involvement of 450 inmates in Safer Sex Week and 1000 inmates in World AIDS Day.

During 2006, the ministry conducted targeted interventions for the security forces, inmates and wards of the correctional centres. In August 2006, the Sexual & Reproductive Health Project, which was piloted at the Tower St. Adult Correctional Centre (TSACC) was absorbed by the Sector & Community Response HIV Prevention Component. One objective of this project is to determine the prevalence of HIV in the Tower Street facility. Under the project voluntary counselling and testing will be provided and data gathering will take place regarding HIV-related knowledge, attitudes and practices of inmates including attitudes towards the provision of HIV prevention, treatment, and care services. To achieve this, a laboratory was established at the site and four correctional officers were also trained in HIV and Syphilis rapid testing. HIV/STI counselling was offered to 1,642 inmates and 36 officers at the facility. During the period, 1,152 inmates and 36 officers were tested. This intervention appears to be worthy of replication.

During 2006, there was improved engagement of uniformed and vulnerable populations, such as soldiers, wards, and inmates, through targeted interventions. Cultural approaches and other innovative methods were used to engage these vulnerable populations in all correctional centres through an intervention titled ‘Out A Road Project’. Behaviour change interventions and numerous training and sensitisation exercises were also conducted. Twenty-six condom vending machines were acquired with 10 allocated for the Jamaica Defence Force and 16 assigned to the Jamaica Constabulary Force.

Ministry of Education & Youth: This Ministry suffered a major setback to its HIV response from June to October 2006 following the expiration of the contracts of its HIV/AIDS response team. However, a Programme Officer was hired to implement the activities of the work plan in October 2006.

The main achievements of this ministry included the acquisition of 1, 995 copies of nine titles on HIV and AIDS for placement on the Jamaica Library Services, 21 mobile units and the development of three (3) anti- stigma and discrimination audio scripts. Innovative World AIDS Day activities performed in collaboration with NGOs, reached 25,000 students.

There was also the evolution of workplace programmes to offer both HIV prevention and on-site rapid HIV testing and behaviour change interventions targeting over 2,600 in-school youth and workplace populations. The ministry has indicated that its HIV response may benefit from improved collaboration between its internal publics, the National HIV/STI Programme and various non-governmental organizations.

Ministry of Tourism, Entertainment and Culture: The Ministry of Tourism, Entertainment and Culture has integrated on-site HIV testing in outreach mass public sensitisation sessions in which over 500 persons were tested mainly in Negril and Montego Bay. It anticipates the establishment of a prevention component in all orientation exercises by 2007.

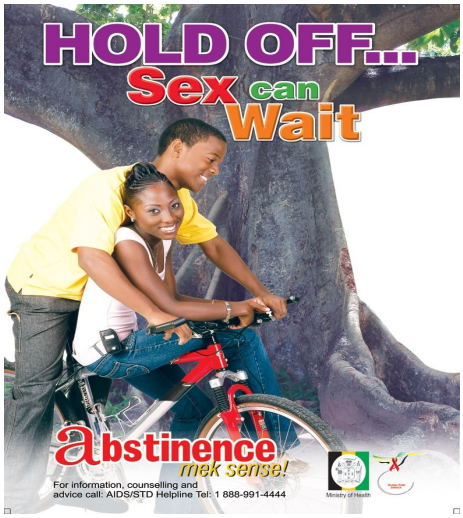
During 2006, this ministry managed to engage a majority of its sectoral publics in HIV prevention. The ministry also trained 705 persons in various areas of HIV prevention. Eighteen condom vending machines were acquired and 11 were placed at various hotels in Negril, Montego Bay, Ocho Rios, and Kingston. There were an increased number of persons trained in Voluntary Counselling and Testing and as peer educators.

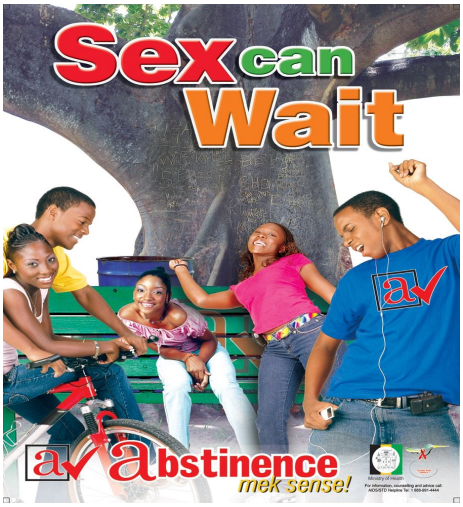
This Ministry indicates that the low literacy levels of a majority of its publics have hampered efforts to conduct meaningful pre and post-tests. Additionally, participant turnout to activities has sometimes been lower than expected despite the receipt of confirmations attained. This has led to the development of on-site interventions targeting hard-to-reach publics, such as vendors and contract carriage operators.

Media Campaigns

Mass media campaigns are used to keep selected messages on the public agenda. They are also used to motivate individuals who just require a “little push” to adopt the suggested behaviour. These campaigns are never used in isolation. They complement other interventions.

During 2006, several campaigns were designed for TV, radio, print (newspapers, poster, and flier), billboards and bus back panels. The campaigns are generally supplemented by face-to-face interventions and a public relations campaign.





One campaign message during the period told persons with HIV to take “ARVs for Life”. Another told the general public that persons living with HIV and AIDS are” Getting on with Life”. Young people were also reminded that “Abstinence Makes Sense”.

The prevention component ensures that all campaign messages for mass media and outdoor advertising avenues are suited to the target audience and tested, refined and approved by a sample of the intended audience. For this reason mass media campaigns under other components are developed in collaboration with the prevention component.

Adherence to ARV: The campaign on adherence to ARVs was targeted to persons living with HIV. It highlighted compliance with medication and instructions provided by the health provider. With the main message: “I am in control not HIV”, one TV spot, three radio spots including a 30 second jingle and three posters formed the basis of the campaign. It was financed by the Treatment Care and Support component and coordinated by the Prevention Team in collaboration with the Treatment team.

The TV and radio messages were aired for three months, while an interpersonal component was aimed at mobilizing the PLWHA community to increase their awareness about the availability of ARVs and general information on treatment.

Insert pictures of posters for ARVs.

Getting on with Life: This kind of campaign was developed and placed for the first time in Jamaica and in the Caribbean. A mass media campaign (described earlier) showed the faces of two persons living with HIV. Real persons instead of actors revealed themselves during prime time advertisements and on billboards and busback panels. The campaign was aimed at reducing stigma and

discrimination affecting persons living with HIV. It comprised two-30 seconds radio advertisements, two posters, two fliers and outdoor advertising.

This campaign, coordinated by the policy component involved the prevention team in all phases. The official launch of the campaign was held during September 2006 with media placements booked for September to December, representing the first flight of the campaign. The messages were placed on leading national media, including print, electronic and outdoor. Discounts for placements were facilitated through the Media Alliance (partnership with the NHP). Seven media companies including CVM TV, IRIE FM and the RJR Group of Companies matched the NHP's placements.

Two campaigns 'Friends Hotline' and 'Abstinence Make Sense' were at various stages of production during the period and should be broadcast and published during early 2007. **Friends Hotline Campaign:** promoting the services of a confidential helpline for adolescents. Adolescents are being encouraged to call and discuss sexual reproductive issues and other personal matters relating to health and relationships. **Abstinence Makes Sense:** This campaign is directed at 12 –1 4 years old adolescents, and promotes the need to delay sex. The decision to delay sex is seen as a choice that really smart young people who are in charge of their life can make. Two radio advertisements and one television advertisement as well as two posters and outdoor advertising for bus panels and billboards were developed.

Reduction of Stigma and Discrimination at the Workplace: This campaign conducted under the Policy/Advocacy component supported by the Global Fund. The first flight of the 'Defend This' campaign (six weeks) was placed by the contracting agency during 2005 between September and November. However, the second flight (two months) of the campaign was scheduled for early 2006. The Behaviour Change Officer of the prevention team negotiated discounts.

Public Relations and Cultural Vehicles

Journalists Training Workshop: The national programme gave technical and financial assistance to Panos Caribbean to host one three-day workshop to train journalists in techniques in covering issues relating to HIV/AIDS. Fifteen journalists from five national media houses received training in techniques in investigative journalism as well as covering sensitive issues relating to HIV/AIDS (including interviewing PLWHA, CSW and MSM).

Websites www.jamaica-nap.org: The official website of the National HIV/STI Programme is currently being hosted by Go-Jamaica, the Gleaner Company's online services division. New features added to the website in 2005-2006 include:

- A web page featuring HIV/AIDS policy issues as well as a link to the National HIV/AIDS Policy.
- Treatment information regarding treatment sites and contact details for treatment counsellors.
- Global Fund link featuring GF reports in PDF format.
- News reports

The websites have been an excellent resource for students, media, local and international partners and other interested individuals. The NHP is looking into using the website more efficiently including advertising job opportunities and showcasing achievements, reports, published articles and other documents.

Special Events

Awareness events are used to engage mass audiences while keeping risk reduction and other related issues such as non-discrimination on the agenda. The first one scheduled for each year is Safer Sex Week which coincides with Valentine's Day (February 14).

Safer Sex Week provides an opportunity to engage people on the ground whether in communities or schools. National celebrities joined the team in 2006 by getting tested for HIV. Among them were the reigning Miss Jamaica Universe, Raquel Wright; Miss Jamaica World Terri Karelle Griffiths; World record 100m-sprint holder Asafa Powell; Jamaican cricketer Gareth Breese; deejays Leftside and Esco.

Esco holding their HIV test strips

100 metre World Record Holder, Asafa Powell gets pre-test counselling

The main event, a health fair on the ground of Devon House dubbed 'Sex in the City' was free HIV testing with pre and post-test counselling. Some 360 persons got tested that day. The event featured more than 30 booths offering information

and services relating to reproductive health including male and female condom-use demonstrations as well as information on living a healthy lifestyle. Renowned edutainment ensemble Ashe and Nomadz mixed facts with laughter and thrills. "Risk Assessment Cards" and "Use a Condom" brochures were used to reinforce prevention options.

Concerts planned and performed by inmates and warders were conducted at all correctional institutions. The Jamaica Red Cross organised a mobile intervention dubbed Safer Sex Bus, while a Safer Sex Fair was the main event in Ocho Rios.

The media broadened the reach of the Safer Sex messages during special broadcast interviews and print features. Media entities included First Edition on KLAS FM, Beyond the Headlines on RJR 94 Fm, Sexwise on Irie FM, Health Watch on CVM TV, The Beat on RJR 94 FM, All Woman in the Jamaica Observer Newspaper, YouthLink in the Gleaner Newspaper and RE TV.

In virtually every parish there were concerts, road marches, library displays, talks and specially designated church services. Many events were conducted as part of targeted community interventions and in Mandeville; the launching of a condom machine was integrated into Safer Sex Week.

World AIDS Day 2006: Some 3,000 people converged on the Emancipation Park on December 1, 2006 with about 50 per cent of them having a meaningful interaction at an information booth or at a speaker's corner. The National HIV/STI Programme hosted World AIDS Day 2006 at the park on December 1st 2006, under the theme "Stop AIDS, Keep the Promise-Get Tested",

The day featured free HIV testing with 950 persons participating. Throughout the day, 10 tents and 36 staff representatives catered to those desiring an HIV test on-the-stop. The unexpected client-size required additional persons who were suitably qualified and on site to assist with the testing process – from recording basic information to pre-test counselling.

Information booths and interactive speakers corners also attracted large groups of people and the media. There were 325 persons participating in the speakers' corner. The speakers' corner incorporated those waiting for HIV test results as well as other onlookers and engaged them in discussions on either parenting, the role of the church in HIV prevention or reducing stigma and discrimination at the workplace.

Public interest and participation in World AIDS Day has increased, particularly from media, non-governmental organisations faith-based entities and public and private sector involvement. The NHP has used World AIDS Day, to place key HIV/AIDS issues on the public agenda and generate useful discussion and participation as well as attract new partners. Below are the results from National

Event and activities held by Regional Health Authorities during November 2006 in commemoration of World AIDS Day (December 1)).

Table: Numbers of Persons Tested and Numbers Positive during World AIDS Day Activities

Organization	Total Tested	Positive
SERHA	1414	20
WRHA	476	13
SRHA	2082	Not available
NERHA	600	3
***SERHA/PLACE**	950	15
Grand Total	**5522**	**51**

*** Indicates National Event

Booths all focused on HIV/AIDS issues from varying perspectives through the NHP Youth Intervention Team, PANOS Youth Journalists, the Jamaican Network of Seropositives, the National Family Planning Board/Marge Roper Counselling Unit, the HIV Vaccine Trials Network and the National HIV/ STI Programme in collaboration with the South East Regional Health Authority.

Newspaper Supplement

The Gleaner which according to media surveys has the widest readership, collaborated with the National HIV/STI Programme and Panos Caribbean to produce a 12-page supplement for World AIDS Day Dec 1st 2006. The supplement was formatted to resemble a miniature newspaper so as to reflect the fact that HIV affects all areas of life just as the Gleaner reports on all areas of life. The supplement featured headlines such as:

- High Demand for AIDS Treatment
- Flirting with HIV
- Business Tycoon Gets Tested For HIV
- Church Must Come to Terms with HIV
- Driver Tell Me 'Bout HIV
- Rebel With A Cause (Artistes Against HIV)

There were also two live radio broadcast from Emancipation Park during the event using Love 101 in the morning and from RJR 94FM in the afternoon.

Material Development

Table: IEC Material Reproduced and Distributed in 2006

Type of material	Audience	Title of material	Quantity
Reprinted Brochures	**Adolescents**	Hot Girl Makiesha	34,000
		Sex Am I Ready?	38,500
		Young & The Restless	43,500
		Frequently Asked Questions	73,700
Reprinted Brochures	**Adults**	STIs that Cause Sores	30,800
		STIs that Cause Discharge	30,600
		Right Way to Use a Condom	68,200
		Do It for Your Baby	20,000
		STD & Me	25,500
		R U Safe	20,000
		Sexually Transmitted Infections	70,000
	Low Literacy Adults		40,000
		Do you know your HIV Status	70,000
		Risk Cards	2,500
		Referral Cards	
New Brochures	**CSW Low Literacy**	Why Should I Get Tested	2,500
		Safe Business is Good Business	2,500
		Risk Cards	1000
New Brochures	**Voluntary Blood Donors**	Somebody's Blood Saved My Life	2000
New Posters	**PLWHA**	ARV for Life	5100
	Adults	Risk Assessment	2000
Reprinted Posters	**Adults**	One Time Fling	2000
		You Have the Power to Choose	2000
		Right Way to Use a Condom	2000
		Risk assessment	2000
	Adolescent Males	Ride Wid it	2000
		Work Wid it	2000
		Get it Carry it	

The Table above demonstrates the type of material and distribution pattern. Distribution was wide with some material such as risk assessment cards and pamphlets about STIs reaching over 70,000 during 2006.

Voluntary Counselling and Testing (VCT)

Voluntary testing and counselling (VCT) and its expansion is the number one priority of the National HIV/STI Programme (NHP). The VCT programme during 2006 was upgraded in the NHP's bid to expand testing and promote the need for everyone to know his or her HIV status.

VCT became a training component of the Epidemiology Research and Training Unit of The Caribbean HIV/AIDS Regional Training network (CHART-Jamaica), while retaining its service delivery character within the National HIV/STI Programme. Not just Jamaica, but other Caribbean states were able to benefit from the VCT training modules offered by CHART. During the process, lessons learnt were shared and recommendations for programme implementation made.

Table: Summary of Trainings to Date

Type of Training	Numbers Performed
VCT Training (Jamaica)	116
VCT training (Other Caribbean)	93
Advanced Training Skills	Jamaica 2 Bahamas 1
Performance Quality Improvements	5
Group Education Training	Jamaica 1 St. Lucia 1
SDM for VCT training	2
Instructional Design	Government 1 NGO 1

The mentorship programme under CHART that engages regional staff involves a PQI sensitisation session and incorporated feedback about challenges in conducting Performance Quality Improvement (PQI) assessments. These assessments also facilitate sit assessments as staff shortage and levels of competence are factors that impact on the consistency, accuracy and thoroughness of these assessments.

Service Delivery

As the programme expanded, critical issues in service provision were addressed by developing training material to fill gaps in knowledge or programmatic intervention where specific population's needs were not being met (i.e. adolescents). The materials developed included Group Education Material, Sexual Decision Making for VCT Training Material and a VCT Service Delivery Manual. The VCT Protocol was also revised to address issues in service

delivery that had changed from the inception of the programme i.e. HIV testing methods.

Staff training in VCT for several private laboratories enhanced service delivery. This training was part of the part of the campaign to scale up testing. PQI evaluations were instituted mainly in Type V and III public health clinics. Although the PQI has been successful in revealing service gaps, it was not used bi-annually as requested by the programme and was somewhat haphazard. Provider Initiated Testing and Counselling (PITC) sensitisation training occurred in all regions by the end of 2006. This approach to scaling up HIV testing highlighted gaps in the various systems relevant to the receipt of an HIV result for example, the flow of results from the health care provider to the laboratory and back to the client.

The Way Forward

The VCT programme may be more efficient if merged with the Behaviour Change Communication (BCC) programme and regional and parish BCC/ VCT officers were assigned. Also necessary is a clear organizational structure, outlining the link to the national programme and CHART-Jamaica. It is necessary to ensure that data gathering forms are completed as required to get a true picture of the level of VCT interventions conducted in the field. This activity and PQI assessments are important steps in monitoring and evaluating the programme.

Treatment, Care and Support for Persons Living With HIV and AIDS

Since public access to antiretroviral (ARV) treatment began in September 2004, 54 per cent or 2,700 persons with advanced HIV have been placed on ARV treatment. Already results of the treatment programme are emerging in a lower number of AIDS deaths. This was evident in the first half of 2006 compared to the corresponding period of 2005.

Much of patient care under the treatment care and support component centred on the existing 18 treatment centres, where a multidisciplinary approach to management is applied. The target of 250,000 HIV tests was not met but approximately one-third or 82,000 such tests were conducted. Also processed were 220 PCR[4] and 5,910 CD4 tests. There were 2,848 samples received for Viral Load testing by the National Public Health Laboratory (NPHL).

Based on pharmacy reports, at December 2006, the number of patients on antiretroviral medication (ARVs) was 2,377 adults and 256 children totalling 2,633 persons. During the year, attempts were made to monitor the ARVs distributed to pharmacies and clients through a partnership with the National Health Fund (NHF). This involved utilizing the existing NHF database for drug management by issuing each ARV client (public and private) with an NHF card. This card is identical to NHF cards for all other conditions and allowed PLWHA to access their medication in a confidential manner. Over 50 per cent of persons on ARVs were registered with the NHF.

The adherence programme provided support for many clients on ARVs. However, the reach of the programme was limited and the average reported adherence level was 87 per cent.

Screening and Diagnostic Services

A whopping 407 per cent increase was achieved in the number of persons tested for HIV during outreach activities 2006. Those tested reached 12,309 in 2006 compared to 3529 in 2005.

Rapid HIV Testing

At least 25 per cent more HIV rapid tests (same-day results) were conducted in 2006 when compared with 2005. From all accounts, 81,956 such tests were carried out in 2006, while 65,684 tests were conducted done in 2005. Despite this increase not even half of the test target of 250,000 was achieved.

[4] PCR – Polymerase Chain Reaction – early diagnosis of HIV

Table 5.1: Number of HIV Tests Done by Quarter in 2006

Quarter	Number of Tests Performed
January to March	18,338
April to June	19,924
July to September	21,050
October to December	22,644
Total	**81,956**

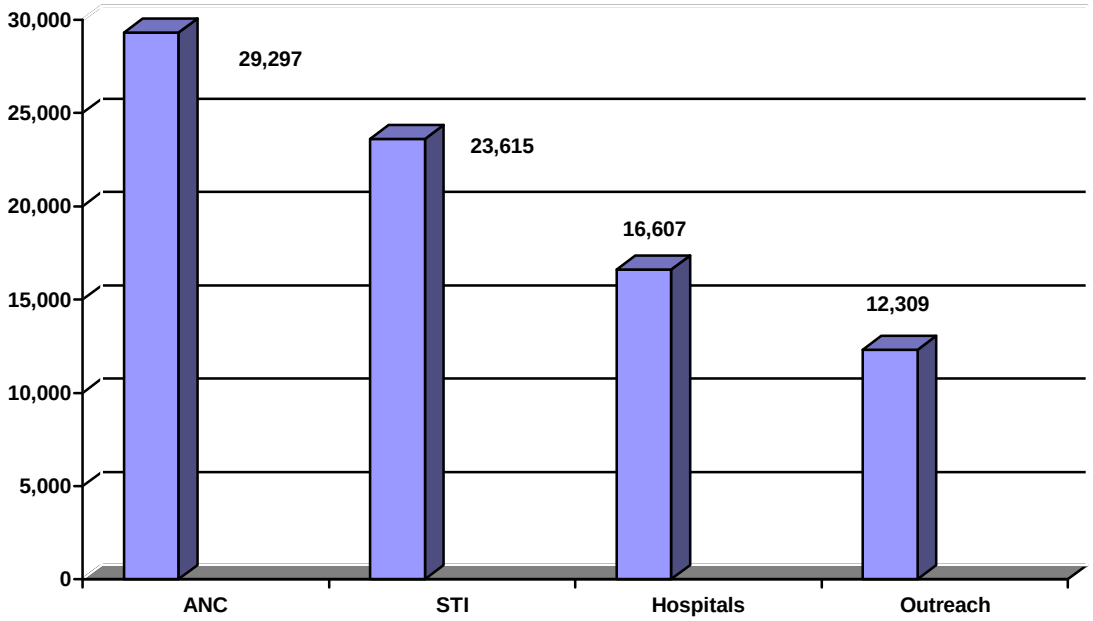
Among the four regional health authorities, the South East Regional Health Authority conducted most of the tests in the amount of 31,160. Amongst those tested, the highest HIV prevalence was noted in from the Western Regional Health Authority with 4.7 per cent.

Table 5.2 below demonstrates the numbers for each region.

Table 5.2: Number of HIV Tests Done and Numbers Positive by Region in 2006

Region	Number of Tests Done	Number of Tests Positive	Prevalence (Those Tested) %
WRHA	19,448	922	4.7
SERHA	31,160	1,409	4.5
NERHA	12,038	503	4.2
SRHA	19,310	470	2.4
TOTAL	**81,956**	**3,304**	**4.0%**

Figure 5.1: Number of HIV Tests Done by Site in 2006



The break down by site is shown in Figure 5.1 above. The 29,297 antenatal samples tested represented only a marginal increase of 1.3 per cent over those tested the previous year. There was a four per cent increase over 2005 for the number of STI patients tested. Fifty eight percent more hospital admissions were tested in 2006 than in 2005. Just about 16,607 tests were conducted compared to 10,510. However, the greatest increase was seen in the number of patients tested in outreach activities. Those tested reached 12,309 in 2006 compared to 3529 in 2005 - an increase of 407 per cent.

Table 5.3: Number of HIV Tests Performed and Number Field Positive by Site of Test for January to December 2006

	STI	ANC	OUTREACH	HOSPITAL
Total Tested	23,615	29,297	12,309	16,607
Field Positive	1,377	526	197	1,186
Prevalence (%)	**5.8**	**1.8**	**1.6**	**7.1**

In 2006, of the total samples tested in the field 3,286 were field positive. This was a 24 per cent increase over last year. The highest prevalence was noted in the hospital admissions followed by the STI clinic attendees.

The analysis of the data (hospital, outreach and STI) by age and gender was not carried out as many samples were submitted without complete demographic data. Another, limitation was that it was impossible to analyse the performance of the rapid test kit in the field because of the pile up of samples awaiting confirmatory tests.

During the final quarter, efforts were made to get provider-initiated HIV testing/opt-out screening of hospital admissions implemented with a December 1, 2006 start date. A one-page counselling checklist for abbreviated pre- and post-test counselling was completed and approved by the Treatment, Care and Support Working Group. Also a three-hour sensitisation/ training for the doctors along with an information package were designed based on the one-page counselling checklist. A few of the smaller hospitals managed to commence this activity however; the major hospitals did not do so.

The President of the Medical Association of Jamaica responded to the request to sensitise the members of his organization to routinely offer an HIV test as part of medical care. Several private laboratories and a few select NGOs were trained in voluntary counselling and testing to facilitate the expansion of HIV rapid testing outside of the public health system. These facilities were certified to offer walk-in HIV voluntary counselling and testing. Additionally, the laboratories will also be accessing viral loads and CD4 counts through the NPHL thus making it significantly cheaper to patients accessing this service in the private sector.

Both laboratories and NGOs have committed to sending regular reports to the NPHL along with submitting samples for quality assurance tests and for routine audits to be performed by the NPHL.

Laboratory Capacity to Identify Indicators of Progression of Infection/Immune Impairment (CD4 count; viral load, PCR and others)

The NPHL started offering PCR testing as a widely available diagnostic service during the first three months of 2006. For the entire 2006, only 220 PCR samples for infants were received. Ten of these were positive, 176 negative, 31, which could not be processed, and three with results still pending. Unfortunately, as is, these figures cannot be used directly to calculate the true prevalence rates of MTCT because they represent the number of tests done rather than the number of infants tested.

During 2006, the laboratory received 2,848 viral load samples and processed 5,910 CD4 samples. The Cornwall Regional Hospital Laboratory in Montego Bay began offering the CD4 test from May. Despite this achievement, many factors such as failure to produce reports on time, staff issues, the management/ ordering and receipt of testing supplies. The CD4 machine was damaged during routine service resulting in the machine being non-functional for an extended period. However, the ordering and supply management problems are being tackled and improvement is expected.

Expanded Access to Antiretroviral Treatment

Since public access to ARV treatment began in September 2004, two thousand seven hundred (54 per cent) persons with advanced HIV have been placed on ARV treatment. The impact of the treatment programme is becoming evident with the decreased number of AIDS deaths in the first half of 2006 compared to the corresponding period of 2005 (196 AIDS deaths from Jan to June 2006 compared to 305 AIDS deaths from Jan to June 2005; 4 pediatric AIDS deaths Jan to June 2006 compared to 10 pediatric AIDS deaths Jan to June 2005). Increase access to testing is a priority in order to identify additional persons in need of treatment.

For much of 2006, the supply of both adult and paediatric ARVs were consistent. During September the directive was sent to the field to commence ordering their supplies (including breast milk substitute) directly from HCL. This removed the Ministry of Health as a third entity through which the order was passed before being filled.

Private sector patients became able to access ARVs at markedly reduced prices. This was achieved via the existing Drug Serv Pharmacies. These pharmacies were supplied via HCL which then facilitated private patients purchasing one

months supply of a triple combination at the government prices of J$2000/month. This mechanism also allowed for some amount of control. Just the prescriptions from physicians who had been adequately trained and certified jointly by the Ministry of Health and the Medical Association of Jamaica, were honoured at these pharmacies.

Prevention of Mother-To-Child Transmission (PMTCT)

The PMTCT programme has been implemented in all major hospitals islandwide and has resulted in the testing of more than 90 per cent of pregnant women attending public antenatal clinics (ANC). This is confirmed by the 2005 MICS conducted by UNICEF that found that 93 per cent of urban women and 87 per cent of rural women who were pregnant within the last 2 years report being tested for HIV during pregnancy. Similarly, the most recent KABP confirmed that public knowledge of PMTCT is high among women (63 per cent). [4]

It is estimated that at least 60 per cent of pregnant women access the public health system and approximately 75 per cent f HIV positive women delivered in public sector and 85 per cent of infants receive ARV for PMTCT. Data on PMTCT in private sector are not readily available.

The PMTCT protocol was reviewed and consensus reached to start all HIV positive pregnant women on Zidovudine/Lamivudine at diagnosis and to add a third drug (Nevirapine if CD4 is below 250 and Nelfinavir if CD4 count is equal to or above 250) once the CD4 count was available. It was also agreed that all HIV exposed infants will be given a single dose of Nevirapine within 24 hours of delivery and Zidovudine suspension for one month regardless of what regime the mother received. The guidelines reflecting this changed were also revised, published and distributed to the field staff.

The Adherence Programme

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The adherence programme has provided support for many clients on ARVs. The social workers and adherence counsellors have contributed to the overall management of PLWHA that attend the public clinics. The reach of the programme is however limited and its delivery inconsistent. Adherence counselling has primarily been entrusted to the social workers and adherence counsellors with no structured duties of other members of the team.

The average reported level of compliance to ARVs across the island was 87 per cent. The southern regional health authority reported levels of 91 per cent, north east region 88 per cent, western region 84 per cent and the south east 83 per cent. Further appraisal is needed to ensure that the measurement tool is consistent. Factors such as no transportation and lack of money affect adherence to medication.

During 2006, strategies were established to improve medication compliance:

Invoice Assistance Programme: The NHP implemented an invoice payment system whereby a patient could be furnished with an invoice valued at up to J$1,000.00 to pay for their antiretroviral medication. These vouchers were made available to persons whether or not they were registered with the NHF.

National Health Fund Registration: The NHP collaborated with the NHF to fast track the process of applications for the NHF cards. Additionally, they collaborated with the Department of the Registrar General to assist in persons getting their birth certificates that is required for one to get a Tax Registration Number, which is a pre-requisite for the NHF Card. The aim was for all PLWHA on ARVs to be registered with the NHF. Up to December 2006, only 1,500 of all patients on ARVs were using their NHF cards.

The adherence programme requires evaluation and revision to ensure that the programme meets international standards for best practice. The counselors will require additional training to allow them to perform the new tasks associated with the changes. The Programme will also to be expanded to include other categories of staff that work at the Treatment Sites.

Medical Management

The major training workshop sponsored by the NHP - the Annual HIV/AIDS Clinical Management Workshop - was during March for three days. The conference was co-sponsored by the Caribbean Epidemiological Centre (CAREC/PAHO) and CHART. Participants included a multidisciplinary team from each treatment site and several physicians from the private sector through the Medical Association of Jamaica.

As has been the practice, drugs for opportunistic infections (OIs) and STIs were procured and distributed by the NHP to all RHAs. The quantities provided were deemed to be insufficient to meet the need.

Revision of the Medical Management of HIV/AIDS Manual commenced during 2006. It is expected that the manual will be available for distribution during 2007.

National Health Fund (NHF)

During 2006, attempts were made to monitor the ARVs distributed to pharmacies and clients through a partnership with the NHF. This involved the NHP utilizing the existing NHF database for drug management by issuing each HIV client (public and private) with an NHF card. This card is identical to NHF cards for all other conditions and allowed PLWHA to access their medication in a confidential

manner. Additionally, it would also ensure that all persons on the Treatment Database were notified to the HATTS System as these cards could be passed through the surveillance department.

While its implementation could be noted as a success, there were many challenges. There was limited support from the pharmacist in the field in using the system. Many pharmacists had little training in the use of the system and thus were limited in their capacity to trouble shoot and interpret certain messages generated by the system. A workshop was held on July 27, 2006 to acquaint pharmacists with the programme. Both the NHF and the Health Corporation Limited (HCL) participated in the workshop. The regional health authorities (RHA) are expected to liaise with the NHF to request and participate in training.

As of December 31, 2006, over 50 per cent of persons on ARVs were registered with the NHF.

Palliative Care (Including Home Based and Hospice Care)

The Jamaica Red Cross Society was to act as the leader in palliative care. This organization has extensive experience in this field and with its island wide network is strategically placed to partner with the NHP and the regional health authorities to implement and monitor this programme. Trainings for both health care providers as well as caregivers were carried out during 2006. It is expected that a register of the trained providers and services available will be established.

Treatment Team

The team which oversees the implementation of the treatment programme and seeks to ensure the maintenance of basic standards of care, continued to meet on a bimonthly basis. The objectives of the team are:

1. To give overarching supervision of the implementation process for Treatment and Care Programme
2. To review protocols for HIV/AIDS management
3. To guide the Testing Protocol for HIV.
4. To develop and implement a training programme for Health sector workers in all areas of HIV management
5. To foster the team approach to HIV/AIDS Case Management

Management of Medical Waste

The NHP has been tacking the problem of medical waste aggressively since 2004 including the increasing the access to education and disposal equipment. Despite the on-going exposure to education and skills building, there was only minimal improvement to the management of medical waste and the availability of

appropriate disposal mechanisms. The programme is in the process of implementing an alternative technology for the management of medical waste. This facility will provide an environmentally friendly means of managing infectious medical waste, inclusive of sharps, and reduce the need for incineration. It will have the capacity to handle most infectious waste generated in the SERHA, but this will be dependent on the level of separation that can be achieved at site of generation. Separation refers to sorting domestic non-infectious waste from infectious. The programme is far advanced in the procurement process of this facility and hopefully a suitable supplier will by identified by the end of January 2007.

After much delay, the programme also procured personal protective equipment and waste disposal supplies including sharps containers and bins, for the major hospitals and HIV treatment centres. These supplies were meant to supplement those provided through the regional health authorities.

Challenges

While much was accomplished, there were challenges. In order for HIV/AIDS treatment care and support to be sustained and fully integrated within the mainstream health services the following challenges must be addressed:

Testing: It is estimated that potentially 15,000 of the HIV infected persons do not know their status; this represents 60 per cent of those estimated to be HIV infected. Young people 15-24 years old are less likely to be tested when compared to those aged 25-49 years. In additional, less than half of CSWs tested in the last 12 months knew the results.

Only about 10 per cent of hospital admissions were tested for HIV, and even smaller percentages from family planning and other regular clinics.

Confirmation of results at the NPHL was grossly inadequate with the turn-around time for results being months at times due to frequent reagent stock outs.

Additionally, the standardized database for the capture of HIV rapid testing data was not widely implemented.

Treatment: In 2006, more than 2,600 adults and children received antiretroviral treatment in Jamaica, a dramatic increase from 2004. However, there is still much work to be done. It is estimated that 4,000 persons are still currently in need. This is estimated to increase to approximately 6000 by 2012.

Unfortunately, two out of three persons infected with HIV seek medical care at a late stage of the disease when the efficacy of treatment and the level of recovery attained may be limted. Individual adherence to medication also is a major challenge and may limit success of the treatment programme. Additionally, poor

sequencing of ARVs by some physicians and the lack of resistant testing are gaps that need to be addressed.

Diagnostic Services and Laboratory Capacity: The National Laboratory has played a significant role in the programme, however, the structure and management of the existing laboratory services does not allow for efficiency. The facility has been heavily reliant on the NHP for funding many aspects of its functioning. For example, between 2002 and 2006 in excess of J$58 million were spent through the NHP on consultancy fees, equipment and supplies.

The capacity to provide CD4 and Viral Loads in accordance with International Treatment Guidelines remained limited, as.did the capacity to diagnose Tuberculosis (TB) and track resistance to ARVs.

TB Screening: The screening of HIV infected persons for TB was limited. There was also inadequate follow up of TB contacts and individuals who were to complete therapy in the communities. Also, the limited as well as centralized diagnostic capacity for TB and the absence of surviellance for multi drug resistant TB adversly affected the success of the programme.

Resurgence of Syphillis: The decline in the prevalence of syphillis has plateaued over the last five years and recently there has been a small but significant increase in the rates of congenital syphillis and syphillis among pregnant women and as well as STI clinic attendees.

Waste Management: Identifying a suitable location for the waste treatment plant presented some challenges. The programme received significant opposition to the proposed Bellevue Hospital site. Although an ideal location and despite the plant having little, if any impact on the community and hospital, the staff of the hospital opposed its placement there based on a history of neglect and poor communication with the Ministry of Health.

Stigma and discrimination: The impact of stigma and discrimination prevents many from getting tested, accessing regular care and/or disclosing their status to their partners. PLWHA often do not want to receive treatment in their community because of concern that others may learn their status. Women, in particular, fear violence from their partners if they disclose their status. There is also a general inadequacy of customer service approaches within the health sector which may also impact on persons Living with HIV

Staff shortages: There was a severe shortage of human resources in the field. Doctors, nurses, social workers, nutritionists and others were all limited in numbers. This limited the extent of the programme. Additionally, the numbers of staff were also threatened by attrition. The lack of routine testing throughout the health system, limited integration with existing health and family planning services, and inconsistent implementation and monitoring of the policies and plans were in part due to this shortage.

Procurement process: The procurement process required for goods, particularly drugs and diagnostic equipment was lengthy. This process could take four to six months at times and threatened the viability of the programme as well as the achievement of targets.

The Way Forward

The purpose of the Treatment Care and Support component is to achieve universal access to high quality comprehensive treatment, care and support in an environment that is non-discriminatory and supports adherence. Building capacity and ensuring sustainability of the programme in the face of imminent cessation of funding is essential. The priority focus for 2007 in treatment, care and support will be:

HIV Testing: Provider initiated testing of hospital admissions and those attending for services within the public and private sector must be prioritized. Further testing efforts must be made by family planning clinics, Type III Health Centres and prisons. Civil society , peer counsellors and outreach workers, also have an important part to play. These partners must be trained, provided with logistical and technical support and monitored for quality assurance. Realistic testing protocols must be developed, implemented and monitored. Outreach activities for those most at risk, such as sex workers, MSM and others, should seek to incorporate rapid HIV testing. The data developed to capture this information will also be more fully utilized.

Treatment: Jamaica has moved forward and have been implementing HAART treatment for persons living with HIV, including children. However, the treatment protocols must be updated to reflect changing treatment and care services according to international practices which are newly recognized. This revision must also include ways to ensure that the laboratory markers, or points at which treatment should be started, are in accordance with international guidelines and are followed. The coverage of persons on ARVs must be improved to achieve universal access targets. In doing this greater efforts must be placed on identifying infected individuals who are unaware of their status by expanding HIV testing. The access to care must also be further decentralized and integrated within existing health services while maintaining key referral centres for expert follow up.

Diagnostic Services and Laboratory Capacity: Focus will be placed on building laboratory capacity in the regional laboratories inclusive of the diagnosis of opportunistic infections. The TB lab will be improved inclusive of modern methodologies for culture of TB and other Mycobacteria. The capacity to carry out CD4 Viral Loads and other supportive investigation must be improved. The capacity for resistance testing for Anti TB and HIV drugs will be explored with a

view to providing resistance testing in appropriate settings as well as to allow for surveillance.

Tuberculosis: Linkages between the TB and HIV programmes will be strengthened with the aim of screening all HIV infected persons for TB as well as ensuring the availability of facilities for early diagnosis. The availability of anti TB drugs will be improved along with the relevant training mechanisms to improve the capacity of the health sector to deliver decentralized TB care.

Other STI: The syndromic approach to the management of STIs has yielded significant success however newly available simple diagnostic technology may make diagnosis of aetiological agents more feasible. Making these test available to guide diagnosis and management will be the key focus.

Waste Management and Infection Control: The goal is to achieve a standard of care in managing medical waste and infection control within health facilities in keeping with international standards. Focus will be on:

- Updating and reprinting of the infection control manual, with widespread distribution
- Training of all levels of health care workers in the management of post exposure prophylaxis.
- Implementation of an alternative technology for medical waste (including sharps) management. Locating a site for the placement of the plant is of the utmost importance. The land area immediately in front of the KPH hospital is considered to be a possibility. Consultations with KSA/SERHA as well as with the Political leadership of that area are being convened to determine the suitability. The procurement process for this item must be concluded with urgency. The current practice of inappropriately transporting infectious waste and inadequate final disposal must be addressed early in 2007.

PMTCT: In keeping with standard international guidelines, triple therapy is now to be offered to all pregnant mothers, as a more viable option with regards to the patients' long term health. Antenatal clinic attendees must also have access to laboratory staging and other diagnostic tests. Specific activities aimed at scaling up this response are:

- Retraining of Public Health Nurses and Midwives to adopt the updated protocol PMTCT+ in 2006
- Screening of all HIV positive pregnant women with CD4 Counts.
- Ensure all women testing positive receive appropriate antiretroviral therapy for prevention of mother to child transmission in accordance with revised PMTCT+ guidelines (Jan. 2006)
- Improve information sharing (M&E) between primary, secondary and national levels.

Contact Investigations: The cadre of contact investigators must be improved to handle the volume of new cases generated from the expaneded testing programme. The management of the CI in the field will also be strengthened and the amount of time spent in the clinics reduced.

Adherence: Adherence to ARVs and care in general will be a major focus during 2007. Strategies will be developed to ensure all providers of care participate in a meaningful way to promote adherence

- Enrolling persons on antiretroviral with NHF, will allow them a further discounted access to medication
- Review TOR of adherence counselors to include counselling for HIV testing as well as adherence counselling on a wider scale, in the hospitals, etc.
- Development of a structured adherence protocol for pre ARV treatment
- Development of treatment support groups.

Treatment support: Strengthening the treatment and care system within the Health Regions is critical to improving public access to quality treatment and care services. There is a severe lack of staff to adequately support the treatment efforts. Moreover, an information tracking system needs to be developed that enables effective management of appointments and medications.

Social support for PLWHA: People living with HIV and AIDS must be empowered through psychosocial support provided through partnerships with NGOs and other sector ministries. Economic opportunities through development of the economy and the provision of job opportunities is also key.

Positive Prevention: Positive prevention programmes must be developed and implemented at all HIV/AIDS Treatment centres and should do the following:

- Integrate expected roles and responsibilities of PLWHAs into existing HIV/AIDS Policy
- Develop standardized messages geared towards encouraging responsible sexual behaviour among PLWHA
- Develop support groups and intervention counselling for PLWHAs attending treatment sites
- Train available adherence counselors in Positive Prevention Methodologies.

Quality Control and Standardization: Guidelines for the management of persons infected with HIV as well as guidelines for post-exposure prophylaxis and infection control must be adopted. The National Plan of Action on OVC, guides the management of children infected or affected by HIV/AIDS at community, family, service delivery and policy levels. A Paediatric Care Treatment Manual has also been developed and must be utilized. One of the future challenges is to work with both public and private providers to ensure that they are following the guidelines. Medical audits will have to be conducted.

Training: In collaboration with CHART specific short courses for HIV case managemnt, PMTCT, Adherence, Infection Control and Counselling will have to be developed and provided to HCW. This will aid in ensuring standardization and quality of care.

Procurement process: The procurement problems must be addressed. Possible solutions are either to harmonize the government procurement process with that of the international donor agencies or else provide special arrangements to facilitate timely implementation of the HIV/AIDS programme.

Monitoring and Evaluation

The national monitoring and evaluation system took shape between 2004 and 2006 with the deployment of a Director and staff during that period. By 2006, six priority areas were identified for monitoring and evaluation (M&E):

1. Refine M & E system with stakeholders
2. Develop data collection tools
3. Develop computerized data systems including an electronic medical record
4. Support implementation of the M & E system in the field
5. Implement the new HATS
6. M & E system for NGOs and other key partners.

Although, the M&E team has made some progress in the priority areas, several gaps in the M&E system and data quality issues are becoming evident. Some important activities and milestones under M&E are highlighted below.

Refine M & E System with Stakeholders
Support Implementation of the M&E System in the Field

Several strategies were used to refine the M&E system and strengthen the role of stakeholders in the M&E system in 2006. An important milestone was the convening of the Monitoring and Evaluation Reference Group (MERG) on two occasions in 2006 after a hiatus of three years. The MERG meetings brought together over 40 representatives of stakeholders in the national response to HIV. These stakeholders included PLWHA, NGOs, FBOs, UN groups, regional health authorities, line ministries, the National AIDS Committee and the National HIV/STI Programme. The first MERG meeting was held on April 19, 2006 in conjunction with UNAIDS and it provided a forum for discussion of national indicators (see attachment). This gave stakeholders the opportunity to review the draft M&E framework including all major indicators in one comprehensive document. A mini-workshop on data utilization was also held and this reinforced the role of the stakeholder in the M&E system.

In the second half of 2006, the MERG participated in the first step of a detailed capacity building exercise supported by MEASURE. This process revealed gaps in the current M&E system, priority areas, and next steps for the capacity building process. A summary of the stakeholders and relationship in terms of importance of a functioning M&E system is shown in Figure 6.1

Key gaps identified by the workshop participants were:

- Gaps in organizational structure of M & E system – lack of clarity of roles, units
- Timeliness of reporting
- Mechanisms for quality assurance
- Communication of M & E results/information to stakeholders

- Electronic networks for communication
- Incentives for performance
- Lack of decentralized decision making

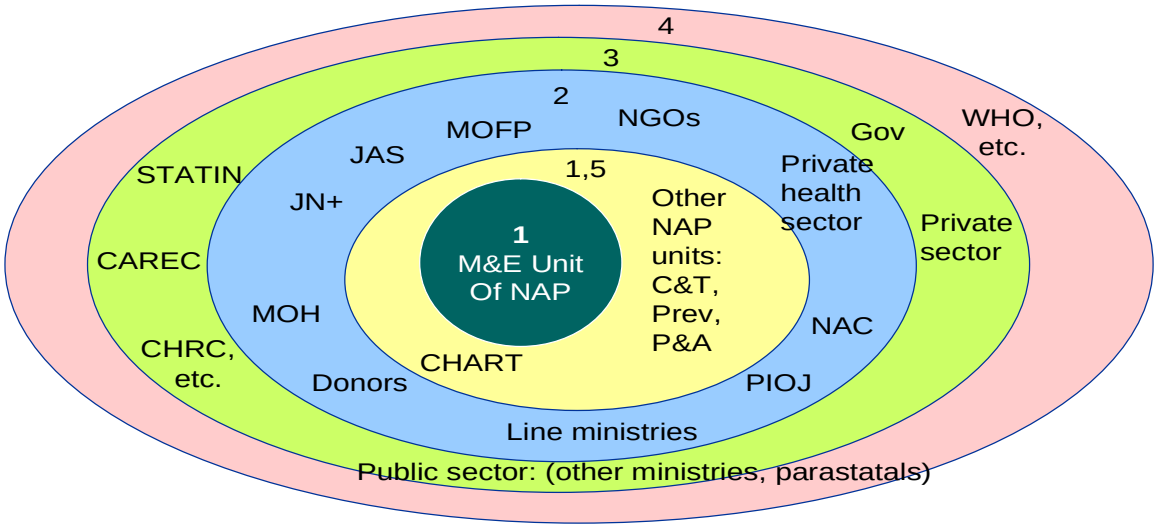


Figure 6.1:

Despite the useful discussions at the capacity building workshop, it was the consensus of the M&E Unit and MEASURE team, that an abridged version of the capacity building process would be more practical and that this exercise must be done in parallel with other M&E priorities in order to fulfil the demands on the current system for accurate and reliable data.

Other activities aimed at refining the M&E system in 2006 were:

Capacity building through regional workshops: Integration of M&E into existing systems including on-going training is critical for the operation of an efficient M&E system. This is increasingly being recognized by the different components of the NHP and priority areas. Consequently, M&E played a role in several workshops, mainly in the form of presentations on indicators and working groups to discuss M&E issues. This included participation in five PMTCT workshops, two NAC/PAA meetings, and parish HIV reviews.

Bridging gaps in data collection and refining data collection tools: Several new data collection tools were developed in 2006. These include stakeholder-

reporting forms, a paper based ART register, regional reports, and new databases such as an electronic ARV register.

The findings of the workplace survey were disseminated in early 2006. The survey looked at anti-discrimination policies at work and provision of workplace HIV/AIDS control programmes at work. This survey is a baseline for assessment of the impact of implementation of national and sectoral policies. The report on sentinel surveillance of ANC and STI clinic attendees was also finalized and disseminated in 2006. A health facility survey instrument was reviewed but it was determined to be a lesser priority at that time.

Collaboration with external groups/technical assistance: The M&E unit benefited from external M&E expertise such as MEASURE, GAMET, and CDC to strengthen aspects of the M&E system such as data collection in vulnerable populations, capacity building and refining the M&E framework.

Refining the M&E framework: The M&E framework (with the support of MEASURE) has been reviewed and is being aligned with the new strategic plan. Discussions with component heads and relevant stakeholders began in 2006 regarding suitable targets.

Participation in the treatment-working group: M&E has played an important role in the treatment-working group by providing information on indicators, interactive demonstrations of databases pertaining to treatment, and providing data.

Convening of an M&E working group: An M&E working group met for the first time in December 2006. This will form a smaller core than the MERG to refine data collection tools and discuss technical data.

Increased role of M&E in the Annual review: The M&E unit has increasingly played an important role in the annual NHP review meeting, which brings together over 100 persons involved in the national HIV/AIDS response. This forum has facilitated discussions about indicators and the targets under universal access.

Identification of targets for donor indicators

Develop data collection tools

The collection of output indicators is a major gap in the M&E system. In 2006, data collection tools were designed, tested and implemented for stakeholders such as line ministries, sub-recipients, and parish AIDS associations. Other tools that were designed include a paper-based ART register (which was introduced to adherence counselors to facilitate data collection on PLWHa on ART), a regional reporting form, and databases (see below) to facilitate data collection and

analysis. An MSM survey is being planned for 2007 with the assistance of MEASURE and a draft questionnaire has been circulated. A summary of some data collection tools that are being processed by the M&E unit is shown below.

Table 6.1:

Report	Responsible Person	Frequency
Contact Investigator (CI) monthly summary statistics	CI	Monthly
Regional Quarterly report	Regional HIV coordinator	Quarterly
Laboratory Rapid Test database summary	Lab supervisors	Monthly
Other Lab Data: No. of CD4 counts, PCR, Viral Loads done	Treatment coordinator (UHWI, NPHL, Cornwall regional (CD4 only))	Monthly
Private Lab reports	Treatment coordinator	Monthly
Line Ministries report	Sector coordinator	Monthly
Sub-recipient report and HADDS	Global fund/ Prevention coordinator	monthly
Other Stakeholder reports including PAAs	NAC	Monthly
Internal program reports (procurement)	Component heads via procurement	Monthly
Regional Progress Report	Regional HIV Coordinator	Quarterly
CHART	CHART medical director	Monthly

Develop computerized data systems including an electronic medical record

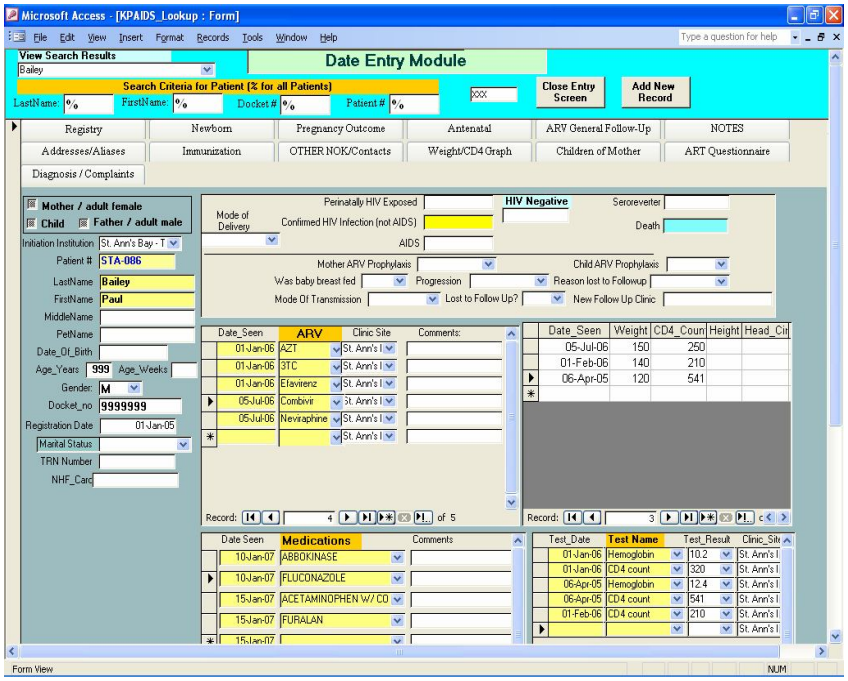
A computerized system is fundamental for the successful establishment of an M&E system. This allows the M&E unit to securely store, collate, and analyze data. Therefore, emphasis has been placed on the development of the HIV M&E information system. Several databases have been designed and are in various stages of implementation:

HATS: A web-based HIV/AIDS case reporting system (HATS) was deigned by a local consultant and several rounds of testing of the database has been completed. Procurement of hardware and software to facilitate implementation of this secured web-based case reporting system has occurred and computers have been distributed to 25 pilot sites. Initial training of users (contact investigators) on basic computer skills have occurred and training on HATS will occur shortly. Options for networking are being reviewed with MIS directors, with consideration for the ability of regions to sustain such a system.

Rapid Test database: A database for tracking of rapid tests done by decentralized laboratories has been designed and installed in regional laboratories. Data entry of 2 years of back-log of data is on-going. Additional computers have been procured to support data entry at parish level as rapid testing takes off and regional labs struggle to cope with the amount of testing data they are processing.

The ARV register: An electronic ARV register has been distributed to 17 of 18 treatment sites. Computers have also been distributed and training on use of the electronic register has occurred at the regional level. Treatment sites have fully implemented the register to varying extents. Most frequently, the lack of personnel to enter the data has been cited as the reason for non-use and at National Chest Hospital, lack of secured space for hardware has delayed distribution of the computer and software.

Fig 1: Screen shot of the electronic ARV register



Stakeholder database: A database was designed by the M&E unit's database officer that tracks implementation of projects and expected outputs. This was abandoned in favour of a new accounting software, ACCPAC, and a finance database. However, some regions have expressed interest in using the database for program management and will continue to do so.

MCSR: The MCSR was revised to capture HIV related data. The revised forms were pilot tested and a TOR was developed for a consultant to design

the database to capture the new variables. However, the interviewing panel was unable to agree on a suitable candidate to complete the task and a suggestion for SITU to revise the TOR and re-interview persons has not resulted in any progress to date.

M&E information system: The flow diagrams and conceptual framework for the M&E information system was discussed in 2006. Initial data entry screens have been designed.

STI aggregate database and STI medical record have been designed by a local consultant. Testing of these systems is about to begin.

Data Dissemination

A fundamental role of the M&E unit is to generate reports and facilitate discussion around the findings, thereby contributing to decision-making and identification of priorities. This is an important strategy to support implementation of the M & E system in the field. In fact, information sharing was listed as a gap in the current M&E system and new routes for informing stakeholders were identified in 2006:

- Publication of the UNGASS report with dissemination to the MERG and other stakeholders
- Dissemination of AIDS epidemic updates to the MERG
- Updating the website with recent reports including KABPs and AIDS epidemic updates
- Presentation of data on the year in review at The Annual Meeting
- M&E participation in various stakeholder meetings
- Establishment of M&E resource centre

Since its inception the M&E unit has generated several reports and is increasingly being recognized as the central clearinghouse for all HIV and AIDS related data. Some reports contributed to and/or generated include:

1. CHRC – report on CIMT indicators
2. CARICOM report on regional indicators
3. UNGASS report on core indicators (2004 and 2005)
4. AIDS epidemic updates
5. CAREC program evaluation
6. GOJ Social Policy Matrix
7. Global fund proposal

Challenges and the way forward

The first draft of the M&E framework summarized over 70 indicators and emphasized the need to truly harmonize indicators. Discussions with donor

groups must now begin in order to reduce the strain on our resources and to yield the most valuable information for programmatic decision-making. The willingness of donors to harmonize indicators and facilitate the development of one M&E system is yet to be seen. This factor combined with demands for numerous reports/ requests for data, surveys, and indicators have proven to be a strain on the small M&E team. Often such reports and surveys are repetitive, suggesting a lack of coordination and communication among international, as well as regional groups. Harmonization on a global scale is necessary to avoid unnecessary distractions.

Despite the increase in staff complement, full implementation of tools is hindered by limited capacity of stakeholders to conduct M&E activities, thereby requiring greater involvement of limited M&E staff to ensure accurate data collection. In addition, some stakeholders are often overwhelmed by the amount of data they are required to collect, often relying on manual systems. In some cases, various data collection tools are already in place and stakeholders are resistance to change of instruments such as new databases.

The M&E Unit's strategies in 2007 are to continue to address the priority areas outlined previously:

Refine M & E system with stakeholders: National indicators must be finalized as a new strategic plan emerges. All stakeholders must be involved in the selection process and must be familiar with the M&E framework. Targets must be set and activities must be aligned with the strategic plan and hence, achievement of these targets.

Develop data collection tools: Inadequate or non-existent data collection tools persist in the private sector and VCT. In other aspects of the programme, data collection tools have been developed but full implementation has been hindered by staff personnel, which are not committed to the M&E system or haven't bought in to the system. These issues will be addressed through capacity building exercises including greater participation of the M&E unit in stakeholder meetings and trainings.

Develop computerized data systems including an electronic medical record and HATS implementation: Several important issues must be addressed as the M&E information systems are implemented. These include maintenance of electronic systems, maintaining confidentiality and stakeholder buy-in for full implementation:

- Support implementation of the M & E system in the field
- M & E system for NGOs and other key partners

Training through CHART

CHART Jamaica, is an official National Training Centre of the CHART Network. It falls under the umbrella of the Epidemiology Research and Training Unit (ERTU) that is a unit under the auspices of the Ministry of Health. CHART Jamaica coordinates many public health-related research studies and training programmes including HIV/AIDS. The organisation is located at the Comprehensive Health Centre (CHC) in Kingston. The CHC is the site of the largest STI clinic in Jamaica, which sees between 50-70 patients with sexually transmitted infections (STIs) per day, approximately seven per cent of whom are HIV positive.

Training Needs Assessment

Training is conducted based on training needs assessments that were carried out by one or more of the following methods:

- Participation in the HIV work planning meetings of the Regional Health Authorities.
- Incorporation of NHCP staff in the ERTU-CHART strategic planning meeting.
- Collection of anecdotal information at workshops and national meetings.
- Collection of data using an instrument at numerous workshops.

The table below demonstrates the number of persons trained between 2003 and 2006.

Table: Participant count by Training Topic – between May 2003 and December 2006

Training Topic	Participant Count
ARH Instructional Design	10
ART	149
Contact Investigator	41
Laboratory	12
Pmtct	91
STI Management	364
VCT Advanced Training Skills	18
VCT Clinical Training Skills	95
VCT Instructional Design	9
VCT Skills	1677
VCT Supervision	27
Other	108
TOTAL	**2601**

Training Materials

Videos, DVDs, ARV laminated pamphlets and booklets on opportunistic infections were developed and issued by CHART to participants at ARV management workshops and to physicians on rotation through the Comprehensive Health Centre. STI booklets produced by NHCP were made available to groups of nursing and medical students and peer educators. STI manuals were also provided for clinicians for purchase.

The CHART Regional Coordinating Unit (RCU) also provided financial and other support to a significant number of training activities throughout the year. The RCU also provided some VCT manuals when JHPIEGO was no longer able to do so. However, this resulted in a charge being attached to the training which was a deterrent for some organizations. The sustainability issue for all training needs serious consideration.

Training Programmes

PMTCT PLUS

The NHCP requested ERTU-CHART to conduct workshops to update staff of Regional Health Authorities (RHA) on the revised PMTCT protocol. The workshops were held between June and October 2006. Workshops were also conducted by the south regional health authority (SRHA) regarding the PMTCT update with approximately 103 participants being trained.

Each workshop consisted of interactive presentations on the steps involved in PMTCT plus, treatment (for mother and baby), psychosocial and nutrition issues and monitoring and evaluation of the programme. The workshops not only provided an update on the new triple therapy PMTCT regimens but also served as a regional networking forum.

Observership Programme at University of Miami

At the request of the NHCP, a two-week observership programme at the Jackson Memorial Hospital was organized. This observership was for local treatment site staff. Assessment of knowledge gained was tested by their responses to clinical scenarios.

The Clinton Foundation provided sponsorship. Six doctors (2 each from WRHA and SERHA and one each from NERHA and SRHA) participated during July to November 2006. The training evaluation forms and trip reports attest to the usefulness and overall positive experience of this observership.

Medical Residents and Other Preceptorships for UWI

Medical residents attached to the Department of Medicine, UWI, Mona rotated through adult treatment sites in KSA. These rotations commenced in February 2006. The Residents saw patients at CHC on Mondays, Tuesdays and Thursdays, at CHARES on Wednesdays and KPH on Fridays. Later as the CHARES clinic grew the residents only came to CHC on Tuesdays and Thursdays. A total of seven medical residents participated in the rotation. An evaluation report for each resident is to be completed and this emphasized the need to formalize the mentorship experience at CHC and KPH and also the need to train the mentors.

The half-day STI preceptorship for final year medical students continued under the leadership of the Medical Director. Nursing students also attended for a 2-3 day preceptorship led by the senior nurse at CHC. Two nurses from Grenada participated in a two-week workshop in December. They were exposed to the surveillance and management of STI/HIV and also M & E from the perspective of the NHCP.

Patient care:

Numerous activities to improve the level of patient care at the treatment sites were undertaken. Below is a list of some of the activities:

- Case discussions via email with Dr. Symes, Consultant Physician of the University of Miami
- Monthly case conferences at CHC or CHARES attended by care teams from both sites. Cases presented included HIV nephropathy, HIV management for substance abusers and toxoplasmosis.

KPH Stigma and Discrimination Reduction Programme in Collaboration with JHPIEGO/Pfizer

Following a baseline survey of 200 health care providers and KPH clients on knowledge, attitude and practices towards PLHA, workshops covering general Information on HIV and Other STIs, Risk Assessment and Reduction, Treatment and Care for Persons infected with HIV and other STIs were held. The first group consisted of ward assistants, porters and security guards. The second group was comprised of nurses and doctors.

Contact Investigation

Information provided to contact investigators (CIs) was updated. This update explored the role of the CIs in rapid testing, PMTCT and ARV management. Special parish reports were shared and case presentations on missed opportunity of congenital syphilis discussed. A study conducted by Emory MPH student Yoran Grant on *Contact Investigation of High Risk Groups* was

presented to the group. Two nurses from Belize attended this meeting as a means of garnering information and ideas to better plan for CI training programmes in their own country.

Challenges and the Way Forward

Staffing continues to be a major challenge for the treatment sites. For sustainability it is important that the government maintains a higher percentage of the staff than it currently does. The poor level of staffing negatively impacts the quality of the learning experience for the students and the workload for the preceptors.

Monitoring and Evaluation

Monitoring and evaluation of workshops was conducted primarily by completion of the TIMS forms, pre and post tests and completion of a training evaluation form. Follow up on training activities was conducted in June 2006. Evaluation was carried out for specific workshops such as those conducted for community health aides, social workers, laboratory workers, as well as the STI/HIV workshop held for KSA medical officers. Persons were interviewed to determine if they were using the knowledge and skills gained. Overall there was improvement. Some however stated that time, technology and support were barriers that prevented them using their skills.

The JPHIEGO VCT programme in the Caribbean was evaluated by USAID. Discussion followed concerning the need to strengthen monitoring of VCT service delivery, to provide increased buy-in to the existing performance quality improvement programme and ensure training for supervisors. CAREC also validated information collected during the VCT evaluation exercise.

Health Systems & Capacity Development

The national capacity of the Ministry of Health and its stakeholders is being strengthened through the component responsible for Health Systems and Capacity Development. Such strengthening will intensify the national HIV/AIDS response by improving the technical, managerial and implementation capacity of the key players within and outside the health sector, in government, and in the civil society, who are involved in the fight against HIV/AIDS. Improved national capacity to tackle the HIV/AIDS epidemic in Jamaica is a main objective of the 2002 to 2006 National Strategic Plan on HIV/AID/STI. This effort addresses gaps identified in the national response in the form of limited commitment from non health organisations and other government ministries.

Three areas were identified for intervention:

- Improved diagnostic capacity of service delivery - improvement in the confidence and reliability of the HIV testing mechanism
- The establishment of regional treatment centres, implementation of a Laboratory Information System at the National Public Health Laboratory (NPHL)
- Planning, management and implementation capacity of NHP, NAC, PACs, RHA and Line Ministries – building the capacity at the regional and parish levels, strengthening the role of health and ensuring that all had access to financial support through the HIV/AIDS Demand Driven sub-projects (HADDS). HADDS utilises NGOs, CBOs and FBOs in the design and implementation of HIV/AIDS interventions.

Activities

Implementation of the Laboratory Information System (LIS) and the related parallel activities received much attention during 2006. This involved expanding the number of treatment centres across the island and increasing the capacity of these and other centres to provide adequate services to clients. Also included was the identification and deployment of staff for critical positions in the project coordination unit (PCU) and the regional health authorities (RHAs).

Achievements

Blood Safety

The National Policy on Blood is now at the final drafting process. Several meetings were held during the year with stakeholders and staff. The policy addresses the following areas:

- Testing, storage and transportation of blood and blood components.
- Blood transfusion - blood donor and recipients issues.
- Staffing of the Blood Bank.
- Disaster Preparedness Plan.

The planned workshops for staff and the general public to inform the final document have been scheduled for the first quarter in 2007.

Improved Diagnostic Capacity of Service Delivery

Laboratory Information System (LIS)

Three firms responded to the invitation to tender and a United States based firm, Starlims, was recommended for contract award. Starlims demonstrated in its oral presentation that it had a robust system, which once configured, would deliver all that was required. The blood bank module was under development but this process would be completed to ensure installation during the stated timelines.

The recommendation for contract award was sent to the World Bank for *No Objection* in September. With the World Bank response pending, the in-country procurement committee and the National Contracts Committee approved the presentation by Starlims. A proposal was also prepared for presentation to the Cabinet in early 2007. At December 2006, the World Bank had not yet issued its approval.

With the expiration of the contract with the LIS Project Manager and the decision not to renew it, the Director, Systems and Information Technology Unit and the Systems Administrator undertook joint responsibility for the administration of the programme. The steering committee continued to guide the process with plans to institute a secretariat comprising key members of all departments to drive the implementation of the LIS software. A Project Coordinator will be hired by April 2007 mainly to drive the implementation of the LIS.

There were several sub-activities under the LIS including network cabling and the purchase of computer equipment. A complete list of all the activities appears in *Appendix 1*.

Civil Works – Treatment Sites

Five sites were identified for rehabilitation/construction works. These were health centres in Spanish Town (St. Jago), Mandeville and St. Ann's Bay, and Cornwall Regional and Savanna-La-Mar Hospitals. Work at the St. Jago and Cornwall Regional sites involved refurbishing of the out-patient areas including painting and replacement of fixtures and the creation of additional office space. The other three sites required the construction of additional space for patients and staff. In addition, a storage facility was being built in Mandeville to replace the old storage area, which was to be renovated and utilized for offices. A contract was signed with Eagle Construction Limited to undertake the activities at all five sites.

A project supervisor was hired in September to oversee the St. Jago, Mandeville and St. Ann's Bay Health Centres. The Western Regional Authority assumed responsibility for the two sites in that region. This arrangement was short-lived as the Savanna-La-Mar site was not adequately supervised consequently the project supervisor's terms of reference was expanded to include that site.

Work on the sites began in August and should have been complete by December. At the end of December, the work at St. Jago and Cornwall were complete with the other sites at 80 per cent completion. The contract with Eagle was extended to January 31, 2007. The contract with the project supervisor was also extended to coincide with this timeline.

During the initial site visit to the St. Jago Health Centre, the need for eight air-conditioning units was highlighted. The issue was previously discussed during the initial discussions on the work to be undertaken at the site but this was not reflected in the bill of quantities. To accommodate the purchase a separate tender was issued. A recommendation was made for contract award and this was ratified by the approving committees at year-end.

Issues Arising

The contractor raised the issue of the inaccuracy in the Bill of Quantities for Savanna-La-Mar and St. Ann's Bay. This was verified by the project supervisor and the Director Health Facilities Maintenance Unit (HFMU). The cost implications are over-runs in excess of 20 per cent above the contract value. HFMU developed the original Bill of Quantities (BQ) and a report as well as revised BQs is pending in order to determine the extent of the errors.

The removal of the pharmacy in St. Ann's Bay to create a waiting area and create a passageway to the treatment centre was delayed. It was originally planned that space would have been created within the health centre for the pharmacy. Increased staff however has resulted in the space originally identified being unavailable. The North Regional Health Authority has therefore decided to

construct additional space, but this will not be achieved within the timelines of the construction activities. Further discussions are to be held with the region.

St. Ann's Bay

The St. Ann's Bay treatment site will be at the back of the heath centre. Access to the facility will be via the existing pharmacy at the health centre. If there is continued delay in the removal of the pharmacy, the side-entrance shown below will form the main entrance to the building with patients exiting the health centre through an existing back door, which is in close proximity.

St. Ann's Bay Treatment site side-entrance which may become the main entrance

Passageway leading to the pharmacy area

Mandeville

Storage Room: Side view

Storage Room: Frontal view

Office Area: Frontal view

Partial view of inside the new office area showing office partitions.

Procurement of Medical Equipment

Disposable items and equipment were purchased for the four regional health authorities based on needs lists provided by the regional HIV/STI coordinators. Two firms were contracted to supply the items and at the end of December, 80 per cent of the combined items were delivered.

Capacity Development

Non governmental organisations (NGOs) are engaged in the national HIV/AIDS response. Many of them have a comparative advantage in reaching adolescents and other vulnerable groups. However, NGOs in the programme have not managed support and donor financing effectively. These NGOs have not been able to institutionalize sustainability and run efficient organizations (staffing, recurrent expenditure). This has resulted in the level of success being below expectations.

The National HIV/STI Programme initially planned to engage a consulting firm to address all the capacity deficiencies. Based on the response to the tender, it was evident that no one firm had the expertise to deliver all aspects. A study tour to Guyana provided information to guide the development of terms of reference for two firms to undertake activities in their area of comparative advantage. Two firms, International Institute for Social, Political and Economic Change (IISPEC) and Deloitte, Touche Tohmatsu, were selected to focus respectively on developing financial and administrative systems and programme Implementation, Monitoring and Evaluation.

Both firms began activities in July but at the end of the year they had not completed their preliminary assessment of the NGOs. This assessment is the

basis for the design of interventions targeted specifically at the entity's area of weakness.

IISPEC presented its first report on the consultancy in January that covered an assessment of the NGOs and provided recommended interventions. The report was not sufficiently detailed and the consultant was asked to revise and resubmit the document.

Both preliminary reports are expected in mid January, based on the projected timelines.

HIV/AIDS Demand Driven Sub-Projects

Training

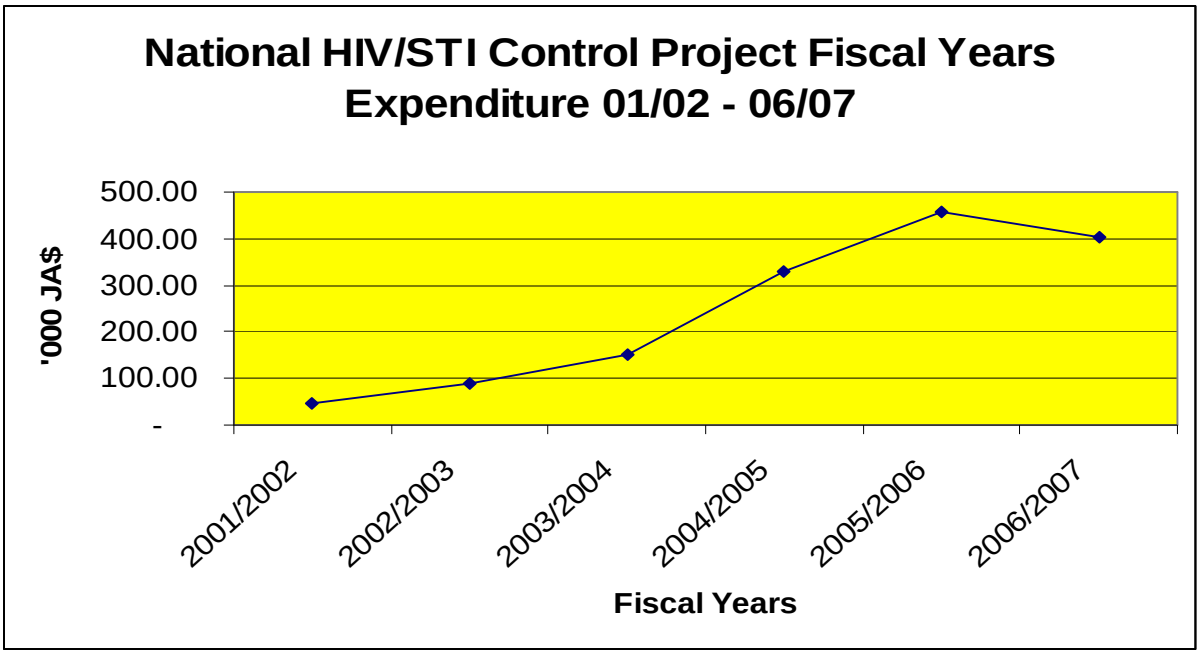
Staff of the PCU, as well as those in the four regional health authorities was exposed to training. The regional technical director from the Southeast Regional Health Authority participated in training on the surveillance of communicable diseases. The Finance/Administrative Officer at the Project Coordination Unit (PCU) was exposed to financial management while two PCU staff and three coordinators from the regional health authorities participated in a workshop on Caribbean HIV/AIDS Project Implementation. Financial assistance was also provided for staff and stakeholders to participate in selected conferences:

- The Chairperson of the Education Sub Committee of the National AIDS Committee and the Legal Officer of the Independent Jamaican Council on Human Rights attended the United National General Assembly High Level Meeting.
- A Medical Officer of Health and the Coordinating Medical Officer of the KSA Public Health Department participated in the 134th Conference of the American Public Health Association.
- The Medical Waste Management Consultant attended the Medical Waste Institute's Annual Conference.

Funding and Support

The national HIV/AIDS response was calculated to cost J$717 million for the year 2006 compared to J$514 million in 2005. The National HIV/STI Programme expended 60 per cent of the budget (J$430 million) in 2006 while it used up 94 per cent or J$485 million during the previous year.

Graph 1



Source: Financial Statements

The National HIV/STI Programme encountered many challenges during 2006 and the flow of funds already committed was not excluded. Early in the year, approval for the work plan supported by the United States Agency for International Development (USAID) was delayed. This meant that financing would also be delayed. Projects supported by the Global Fund grant to scale up treatment, prevention and policy efforts in Jamaica were also held up. This was due to the gap between funding phases. Interventions supported by the World Bank were put on hold for a short period due an alteration in the fund flow mechanism for the 2006/2007 fiscal year. Warrants were received late that were to support advances to the Regional Health Authorities and government counterpart expenditures. Based on the funding situation, about J$100 million allocated for antiretroviral treatment will be incurred in mid 2007. In addition to the financial challenges, the programme activities were also retarded by the bureaucratic procedures of the procurement processes. These have significantly delayed the implementation and expenditure of many activities such as the

procurement of the Laboratory Information and Waste Management Systems. A comparative summary for 2005 and 2006 per components and implementing entity is given in the below:

Table 1

	Calendar Year 2005		Calendar year 2006	
Components	**Budget ('000 JA$)**	**Actual ('000 JA$)**	**Budget ('000 JA$)**	**Actual ('000 JA$)**
Treatment, Care & Support	225.011	195.180	409.775	111.286
HIV Prevention	132.902	113.308	111.782	105.964
Capacity Building	28.257	24.187	42.344	71.336
Policy & Advocacy	33.540	37.200	34.665	22.215
Monitoring & Evaluation	9.619	2.085	7.517	3.466
Administration	68.761	77.158	78.346	58.135
HADDS	2.802	10.149	0.975	6.232
RHA	9.500	23.993	24.655	42.059
Line Ministries	3.624	2.392	7.569	9.847
Total	**514.016**	**485.652**	**717.628**	**430.540**

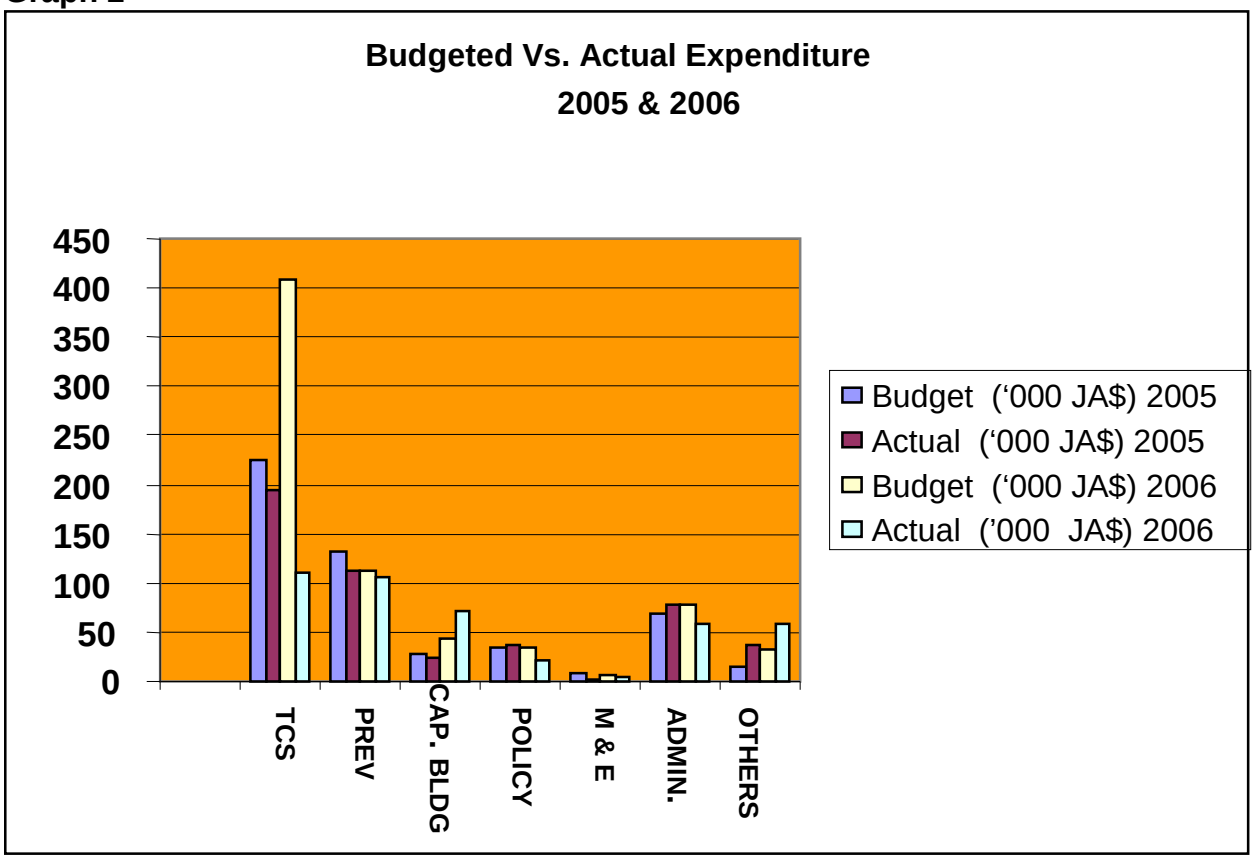
Source: Financial Statements

The resources support Administration and four component areas - Prevention, Treatment, Capacity Building and Policy.

Over the two periods, the budget allocation for the treatment component increased by 45 per cent. This occurred because of the scheduling of the procurement of ARV over the periods. In 2006 the budgeted amount was front loaded, to occur early within the project year due to uncertainty that surrounds actual procurement approvals. The payments of the related amounts are on schedule for early within the 2007 calendar year.

The capacity band health systems development component also increased specifically because of additional civil works to be undertaken in conjunction with work on the Laboratory Information System. Regional Health Authorities and Line Ministries have demonstrated a greater level of ownership in addition to receiving support staff under the programme, hence the increase in the budgeted and actual amount for 2006 calendar year.

Graph 2



Source: Financial Statements

Funds were expended mainly for the following interventions: mass media and outdoor advertising campaigns, procurement of condoms, a special intervention - Priorities for Local AIDS Control Efforts (PLACE), Targeted Community Interventions, special activities for Safer Sex Week and World AIDS Day, procurement of ARV drugs, procurement of rapid test kits, infant formula and STI and OI Drugs, Reagents for PCR test and Viral Load test, medical equipment and supplies, waste management supplies, civil works for treatment sites, monitoring and evaluation activities, Computer hardware including antivirus software and computer software to support the Laboratory Information System and M & E.

Appraisals

Final Audited Financial Statements were received for the World Bank Project, a draft was received for the Global Fund Project and the audit of the USAID resources will commence early within the next Calendar year.

The Consultancy Firm, KPMG was contracted to perform a Human Resource Needs Assessment for the programme. This exercise was undertaken to document a series of options that could be adopted by the government in

consolidating the National HIV/STI Programme as the 'One Authority' on HIV/AIDS and to determine the realistic human resource needs to sustain the programme. This was also used to initiate action towards the absorption of some critical posts within the government structure.

Conclusions and Recommendations

The year 2006 marks the end of a major phase of investment and considerable success in five-priority areas. There is however no room for complacency if Jamaica intends to significantly reduce HIV incidence and HIV-related discrimination. Achievements and impact surveys have paved the way for the 2007 to 2012 National Strategic Plan in its conceptual stage at the end of 2006. The new strategic plan, will seek to expand prevention to 10 times its coverage level while it attempts to achieve universal coverage for treatment care and support. This plan will also seek to ensure an enabling environment for human rights and empowerment for effective governance.

Policy Advocacy Legal and Human Rights: Supportive legislation for policy is now necessary for the sustainability of access to services and treatment for all including vulnerable groups and persons living with HIV and AIDS. For this to be given increased attention, the National HIV/STI Programme (NHP) will use resources to hire a dedicated legal officer to coordinate the process of moving policy into legislation. This officer will work in consultation with the programme manager for policy/advocacy and an advisory committee. The officer will also liaise directly with the legal and ethical sub committee of the National AIDS Committee (NAC).

Other workplace interventions should lead to the integration of HIV/AIDS into the operational and corporate plans of public and private sector entities. This can only be achieved by engaging more players on a full-time basis to ensure a broader reach.

During 2007, the capacity of the Jamaican Network of Seropositives (JN Plus) should be strengthened as a viable legal entity guided by an effective Board constitution and ensuring that members and other persons living with HIV and AIDS are trained and empowered in self sufficiency.

The policy component will take step to help build the capacity of the National AIDS Committee (NAC) to be able to manage its financial/administrative and programme development affairs. This will enable this entity to coordinate true participation in multisectoral involvement.

With the establishment of the Jamaica Business Council on HIV/AIDS (JABCHA), there is need for collaboration to ensure that this entity assumes its rightful leadership in developing and consolidating the business sector response to HIV/AIDS. Other existing entities such as the Jamaica Employers Federation (JEF), the Jamaica Confederation of Trade Unions (JCTU) and the Ministry of Labour and Social Security (MLSS) will ensure tripartite involvement in the

integration of HIV/AIDS issues in operational and corporate plans of the public and private sectors including not just work sites but educational institutions.

Bibliography