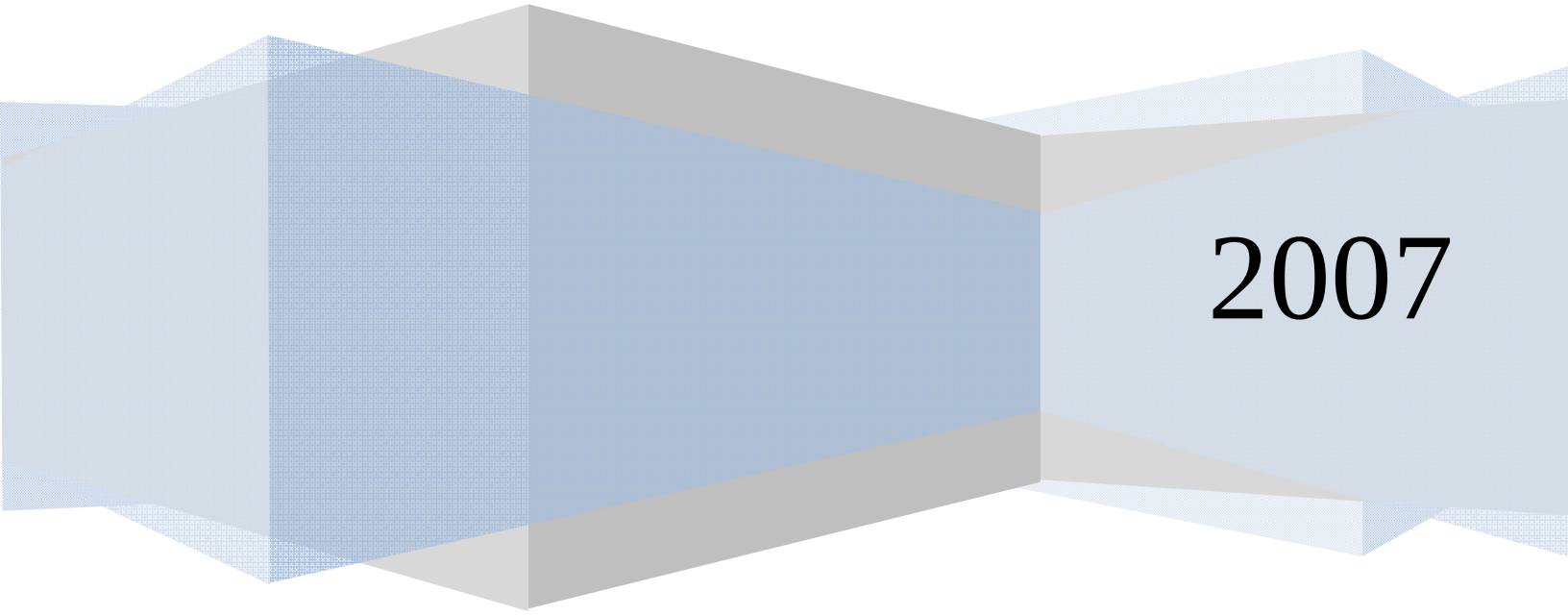
Ministry of Health and Environment

Annual Report

National HIV/STI Programme



2007

Acknowledgements

Every member of the team participated in the development of this report by submitting an annual account of how objectives were implemented and evaluated. Team leader Professor J. Peter Figueroa passed the baton into the capable hands of Dr. Kevin Harvey during the period reviewed in this document. Dr. Debbie Carrington and Faith Hamer compiled the 2007 annual report from information submitted by component coordinators, regional directors and project managers.

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Preface

Topping the list of greatest achievement for this period is the outcome of the prevention of the mother-to-child transmission programme (pMTCT). Compared to previous years, there was a significant decline in the rate of transmission. In addition, the first half of 2007 continued to show the effects of access to antiretroviral (ARV) medication for people living with advanced HIV and AIDS. While these achievements are laudable, prevention of new HIV cases remains the mainstay of the national HIV/AIDS response in Jamaica. In 2007, the country retained its HIV prevalence rate in the general adult population of 1.5%. The numbers of persons reported with AIDS reached 12,520 at the end of 2007 with nearly 7,000 reported deaths due to AIDS. These figures were not included in the report as surveillance data were not updated at the time when the main text was compiled.

The epidemic in Jamaica is both generalised in the adult population (20-49 years) and concentrated in various sub populations. In addition, high risk behaviours combined with poverty and socio-cultural practices fuel the epidemic. Prevention efforts were scaled up during 2007 to include more defined sites for targeted interventions based on research data comprising expanded efforts for voluntary HIV testing with counselling at outreach events. During 2007, there were continuing efforts to implement the National HIV/AIDS Policy using workplace policy development and implementation as a tool. Much more support and commitment is needed from leaders at the highest level including parliamentarians. For next steps we look forward to expanded efforts to ensure that HIV/AIDS is mainstreamed into corporate and operational plans. It is also critical for the national HIV/AIDS response to remain evidenced-based. The response must also involve civil society at greater levels in implementation and in the monitoring and evaluation framework.

Dr. Kevin Harvey
Senior Medical Officer, HIV/STI

List of Tables and Figures

Epidemiology of HIV/AIDS in Jamaica

IN 2007, Jamaica retained its estimated HIV prevalence of 1.5% among the general adult population. Sentinel surveillance of women attending antenatal clinic (ANC) indicates that there has been no significant change in the prevalence of HIV over the last decade. Prevention efforts have slowed down the epidemic.

Jamaica's HIV/AIDS epidemic is both generalised and concentrated. For this reason, higher HIV prevalence rates continue to show up in some vulnerable populations. The seroprevalence rate among sex workers (SW) was recorded at 9%, and it was estimated that 25% to 30% of men that have sex with men (MSM) were HIV positive. There were 36 persons found to have HIV in every 1,000 persons with sexually transmitted infections (STIs). Just 5% of crack/cocaine users and 3.3% of prison inmates were HIV positive (Table 2).

Table 1: Epidemiological Profile: HIV/AIDS indicators

Indicators	Value
HIV prevalence rate, aged 15-49	1.5% (2005, sentinel surveillance of ANC sites) 1.3% (2007, sentinel surveillance of ANC sites)
HIV prevalence rate among CSW	9.0% (2005, second generation surveillance of SW)
HIV prevalence rate among MSM	25% to 30% (2006 estimate)
HIV prevalence rate among STI clinic attendees	4.6% (2005, sentinel surveillance of STI clinic attendees) 3.6% (2007, sentinel surveillance of STI clinic attendees)
HIV prevalence rate among inmates	3.3% (2006, surveillance of inmates)
Reported AIDS deaths	432 (2006, HIV surveillance system)

High-risk behaviours combined with poverty and socio-cultural practices fuel the epidemic. The risk-taking behaviours include decreasing age of sexual debut, multiple partners, inconsistent and non-use of condoms by a subset of the

population. The growth of sex tourism and the expansion of the local sex work industry have also contributed to the spread of HIV.

Table 2: Reported AIDS Cases in Jamaica, 1982 to 2007

Time Period	Total	Male	(%)	Female	(%)
Cumulative 1982 – 2007	12063	6973	(57.8)	5090	(42.2)
Jan – Dec 2000	903	515	(57.0)	388	(43.0)
Jan – Dec 2001	939	511	(54.4)	428	(45.6)
Jan – Dec 2002	989	580	(58.6)	409	(41.4)
Jan – Dec 2003	1070	611	(57.0)	459	(43.0)
Jan – Dec 2004	1112	603	(54.2)	509	(45.8)
Jan – June 2004	578	334	(57.8)	244	(42.2)
Jan – June 2005	473	275	(58.1)	198	(41.9)
Jan – June 2006	451	256	(56.8)	195	(43.2)
Jan – June 2007	324	190	(58.6)	134	(41.4)

At the end of June 2007, the cumulative number of persons reported with AIDS in Jamaica was 12,063. Of that number 6,848 represent reported deaths due to AIDS within the same period (Table 3). Approximately 65% of all reported AIDS cases in Jamaica fall in the 20-44 year old age group, and 90% of all reported AIDS cases are individuals between 20 and 60 years old.

In 2006 alone, the number of young girls between 15 and 24 years, newly reported with AIDS, was two times higher than boys of the same age group. Significantly more men between 35 to 60 years were reported with AIDS than women their age.

By the end of 2007, it was estimated that 6,000 persons had advanced HIV and were in need of treatment. Over 60% of persons in need of treatment were on antiretroviral (ARV) medication. The first half of 2007 continued to show the effects of increased access to ARVs and enhanced supportive services **(**CD4 counts, viral load etc). There were 324 new cases of AIDS (190 males and 134 females) reported between January and June 2007 compared to 451 persons during a similar time span during 2006. In addition, 175 deaths (112 males and 63 females) were due to AIDS in the first half of 2007 compared to 196 in the corresponding period of 2006. Similar trends were seen in the paediatric population.

Table 3: Reported AIDS Deaths in Jamaica, 1982 to 2007

Time Period	Total	Male	(%)	Female	(%)
Cumulative 1982 – 2007	6848	4127	(60.3)	2721	(39.7)
Jan -Dec. 2001	588	329	(56.0)	259	(44.0)
Jan -Dec. 2002	692	406	(58.7)	286	(41.3)
Jan - Dec 2003	650	381	(58.6)	269	(41.4)
Jan - Dec 2004	665	377	(56.6)	288	(43.3)
Jan – June 2004	277	157	(56.7)	120	(43.3)
Jan – June 2005	305	187	(61.3)	118	(38.7)
Jan – June 2006	196	117	(59.7)	79	(40.3)
Jan – June 2007	175	112	(64.0)	63	(36.0)

Figure 1:
Core Indicators for the Implementation of the Declaration of Commitment on HIV/AIDS, Jamaica: January 2006-December 2007 reporting

Indicators	
National Commitment & Action	
Expenditures	
1. Domestic and international AIDS spending by categories and financing sources	TBD (complete NASA report available on NHP website)
Policy Development and Implementation Status	
2. National Composite Policy Index National Composite Policy Index **Areas covered**: gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation	See Annex 2
National Programmes (blood safety, antiretroviral therapy coverage, prevention of mother-to-child transmission, co-management of TB and HIV treatment, HIV testing, prevention programmes, services for orphans and vulnerable children, and education)	
3. Percentage of donated blood units screened for HIV in a quality assured manner	100%
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	50% (2005 – ARV Programme monitoring) 53% (2006 – ARV Programme monitoring) 61% (Nov 2007 – ARV programme monitoring) -It is estimated that there are 6,000 Jamaicans living with advanced HIV.
5. Percentage of HIV positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	47% (2004 – PMTCT Programme monitoring) 65% (2005 – PMTCT Programme monitoring) 85% (2006 - PMTCT Programme monitoring) 85% (June 2007 – PMTCT Programme monitoring)
6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	64% received co-trimoxazole; 72% received ART (2006 National TB programme records) -There were 25 HIV positive incident TB cases in 2006, and it appears that all who met criteria for ARV received such treatment.
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	Men: 12.2% Women: 18.3% (2004, National Knowledge, Attitude, Behaviour and Practices (KABP) survey)
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results	43% of SW (2005 second generation surveillance of 450 female sex workers)
9. Percentage of most-at-risk populations reached with HIV prevention programmes	60% of SW (2005 second generation surveillance)

10. Percentage of schools that provided life skills-based HIV education in the last academic year	24% of 1014 primary and secondary schools (2007, Ministry of Education HFLE Programme monitoring)
Knowledge and Behaviour	
11. Current school attendance among orphans and among non-orphans aged 10–14*	0.97 Male; 1.01 Female 0.99 urban; 0.99 rural (2005- Multiple Indicator Cluster Survey)
12. ** % of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission **(Target: 90% by 2005; 95% by 2010)**	38.1% of 15-24 y.o; 45.9% of 25-49 y.o (2004 National KABP) Females 46.7%, Males 22.8% (2004 KABP) Women: 59.8% (urban), 57.9% (rural) (2005 MICS)
13. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	26.1% of SW (2005 second generation surveillance)
14. Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15	Men: 47.7% Women: 15.2% (2004 KABP)
15. Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	Men: 48% Women: 11%(2004 KABP)
16. Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse*	Men: 66.9% Women: 53.8% (2004 KABP)
17. Percentage of female sex workers reporting the use of a condom with their most recent client	84.2% (2005 second generation surveillance)
18. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Data collection underway
19. Female and male median age at first sex	17.2 Females, 15.7 Males (2004 KABP)
20. ****** % of young women and men aged 15-24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner	66% Females, 74% Males (2004 KABP)
Impact	
21. **% of young women and men aged 15-24 who are HIV infected **(Target: 25% in most affected countries by 2005; 25% reduction globally by 2010)**	1.1% (2004 sentinel surveillance of ANC clients) 1.5% (2005 sentinel surveillance of ANC clients) 1.3% (2007 sentinel surveillance of ANC clients, preliminary)
22. Percentage of most-at-risk populations who are HIV infected	9% of SW (2005 second generation surveillance) 3.3% of inmates (2006, Surveillance of inmates) 25% – 30% est. (2007, estimated prevalence for MSM – Data collection in progress)
**** Millennium Development Goals**	

Prevention

THE year 2007 marked a new phase for scale-up of coverage to prevent new HIV infections and this, under a new five-year HIV strategic plan (2007-2012). It was a time and opportunity for reflection and evaluation to determine strategies required to achieve an expanded response to HIV reduction. A significant feature during 2007 was the close attention paid to the development of monitoring and evaluation tools to ensure that prevention interventions were both more evidence-based and more sustainable.

The priorities identified for the prevention component included:

- Expansion of coverage of HIV prevention interventions to adolescents in schools through scale up of the Health and Family Life (HFLE) curriculum in 150 schools;
- Increasing the involvement of non-governmental organisations (NGOs) and other sectors and also to build their capacity to conduct more effective prevention interventions;
- Increased coverage of the vulnerable populations such as adolescents (particularly unattached and out-of-school youth), sex workers (SW), men who have sex with men (MSM), illegal drug users and the incarcerated persons.

Programme Achievements

Targeted Interventions for Vulnerable Populations

Sex Workers (SW)

The regional health authorities (RHAs) maintained active programmes with the sex worker population. The focus was on condom use and condom negotiation skills along with risk assessment. Many workshops for this vulnerable group were conducted across the island and several included a self-empowerment section, which covered topics such as financial management and parenting skills. HIV testing and referral for care of HIV and other sexually transmitted infections (STIs) were also part of the services offered. Creating and maintaining a supportive environment was also a priority. For successful intervention it was necessary to have the support of the owners and operators of selected establishments.

Table 4: Number of Sex Workers reached by region during 2007

	NUMBERS REACHED		CONDOMS DISTRIBUTED	
	MSM	CSW	MSM	CSW
NERHA	517	415	1815	11219
SERHA	187	215	888	611
SRHA	482	730	2892	17678
WRHA	53	1378	158	7644
TOTAL	1239	2738	5753	37152

Further implementation of the project called Priorities for Local AIDS Efforts (PLACE) was undertaken during 2007. This process identified sites were people meet new sex partners, confirmed sites and intervened in sites using a Randomised Control Trial (RCT) model. The PLACE team that operated out of the National HIV/ STI Programme (NHP) built upon previous efforts to interact with sex workers at street sites. Of 151 encounters in the first half of the year, 60 were contacts with individuals who had previously been trained as peer educators. From May to September 2007, monthly half-day empowerment workshops were conducted. These workshops featured presenters with wide and varying experiences from the National Council on Drug Abuse (NCDA), the National Housing Trust (NHT) and those with expertise in dealing with sexually transmitted infections (STIs) and epidemiology. HIV tests were also offered to all participants. Feedback from participants corroborated the usefulness of the interventions. Those reached pledged to submit a list of new peers to participate in similar workshops.

Men Who Have Sex with Men (MSM)

Traditionally, it is not easy to reach the population of men that have sex with men (MSM) in Jamaica. Despite the challenges experienced, regional health authorities (RHA) have implemented strategies that have worked. The use of community peer educators (CPEs) is one strategy that produces desired results. The NHP through the RHAs has collaborated with NGOs such as the Jamaica AIDS Support for Life (JASL) for right of entry to selected groups and the employment of MSM as community peer educators. Peer education workshops and other interventions were conducted using drama, role plays and group discussions to build skills in condom use, condom negotiation and self-efficacy.

Incarcerated Adults

About 73% of prison inmates and all officers at the Tower Street Adult Correctional Centre (TSACC) in Kingston have been tested for HIV. Seventy one percent (71%) of inmates have been tested for Syphilis and 60% for Hepatitis B, while 64% of officers have been tested for both. Testing was facilitated during a special intervention conducted during 2007. Since the inauguration of the programme targeted to inmates in 2002, counselling in relation to HIV, Syphilis and Hepatitis B reached 2,129 inmates and 53 officers. Table 5 below demonstrates the numbers of inmates counselled and tested during 2007. HIV prevalence in this population was 4.6% compared to 1.5% in the general population. Among challenges were (1) how to monitor treatment compliance, (2) care and support for persons living with HIV (PLHIV), (3) lack of co-ordination with other HIV/STI education and prevention efforts, (4) reported breaches in confidentiality and staffing issues at the Tower Street Adult Correctional Centre (TSACC). The direct and continuous involvement of the prison administration strengthened the process. Another feature of the intervention which should be replicated and sustained is the inclusion and involvement of inmate peer educators and the facilitation of other medical screening tests such as glucose profiles for diabetes.

Table 5: Number, TSACC Inmates Counselled & Tested for HIV/ STI, 2007

Test	Counselled	Accepted	Declined	Tested	Negative	Positive	Prevalence
HIV	492	458	34	458	437	21	4.6%
Syphilis	492	451	41	451	450	1	0.2%
Hepatitis B	492	451	41	451	443	8	1.8%

Source: TSACC *database

Youth Interventions

The national programme categorises youth among the most-at-risk and therefore this population group is part of the priority target audience identified by the NHP. During 2007 interventions were tailored to the needs of in-school adolescents, out-of-school youth and incarcerated young people.

In-School Adolescents: One inner-city school was selected for a pilot project under the leadership of a Youth Intervention Officer. The pilot interventions were divided into two phases: the first occurred when school was in session and the second during a summer camp. This first phase created opportunities to reach more than 400 students during school time. The interactions were to discuss prevention options in relation to the sexual transmission of HIV/STI. Face-to-face interventions and a complementary mass media campaign focussed on the theme: "Hold on, Hold off, Abstain, Get the skills". In-school sessions were carried out using drama, group discussions and games covering topics of self-esteem, emotional changes and sexual urges, gender and gender expectations, relationships and HIV/ STI transmission. During the face-off with the students, high levels of sexual activity and marijuana-use were reported, as well as poor reading skills and lack of respect for authority.

One main objective of the summer camp was to train students to replicate various aspects of the intervention. Forty camp attendees were exposed to HIV/AIDS through gender-sensitive approaches and sessions dealt with sexual experiences and relationships. Participants showed improvement in teamwork, individual assignments and decorum. The campers were later responsible for planning the school's World AIDS Day 2007 activities and also for conducting weekly meetings with their peers. As a follow-up, training workshops were conducted and resource material provided.

Other interventions for in-school adolescents aged 10-29 years were conducted by the Northeast Regional Health Authority (NERHA). Risk reduction interventions were also conducted for persons between 15–29 years at the Jamaica Foundation for Lifelong Learning (formerly JAMAL). The Moneague College also received support from NHP for its HIV/AIDS Awareness Club. Safer sex posters such as risk assessment posters and condom-use posters were mounted in the bathrooms of the four dorms. The team also facilitated a five-day summer camp at the Carron Hall Anglican Church with 15 young people aged 10–19 years.

Out-of-School Youth: Youth outside of the school environment have always been considered particularly vulnerable. The regional health authorities trained "peer links" while mobilizing key resource persons within communities and collaborating with agencies already targeting out-of-school youth. Interventions in youth clubs, community walks and talks and special events were also common. Interventions aimed at HIV/STI risk reduction were conducted in a number of

children's homes particularly in areas under the purview of the Southeast Regional Health Authority (SERHA). The team responded to several requests to address the high level of sexual activity among the state wards. Self esteem, sexuality and HIV/STI were the main areas covered. Risk assessment as well as condom-use and condom negotiation skills were also agenda items for workshops. HIV testing was part of the intervention for the sexually active in the population.

Incarcerated Youth: The majority of reported interventions conducted for incarcerated youth during 2007 took place in communities associated with the Northeast Regional Health Authority ((NERHA)**.** Over 110 boys and girls aged 10 -19 years benefited from these activities. In two institutions for girls, the video 'Teenage Sex Joy or Peril' was used to generate discussions on safer sex practices. In one of the institutions for males 12–18 years, it was reported that their knowledge of HIV/STI transmission was fairly good but their perception of risk was low as were their condom-use skills. It was also revealed during discussions, that these male adolescents had sexual liaisons mainly with older women. This intervention will be expanded in 2008 to further explore issues surrounding reproductive health and healthy lifestyles.

Targeted Community Interventions (TCIs)

Targeted community interventions (TCIs) were carried out chiefly in the southeast and northeast regions during 2007. Communities were selected based on the reported high risk of HIV transmission. Seven targeted interventions took place in the southeast region. All interventions began with surveys to create baseline data. Just two of the surveys were analysed during 2007. Peer links were trained in all communities except one. Violence continued to be a major threat to the success of the interventions in this region.

BCC community peer educator, Carol Cooke in blue shirt, "reasoning wid de man pan de corner"!

Numerous community walks, face-to-face sessions were conducted in the environs of health centres. Interventions that engaged the community residents were also implemented where persons meet new sex partners such as bus stops, market places and shopping malls. Out-of-school youth, unemployed persons and other sexually active persons were targeted. There were more interactions with men than women possibly explained by higher employment rate among females resulting in more males being at home “on the corner”.

Table 6: Number of Condom Interventions By Parish, SERHA

Condom Interventions	St. Thomas	St. Catherine	KSA	Total
Number of Males	3893	854	997	5744
Number of Females	2148	960	1379	4487
Condoms Distributed	8000	5387	8186	21573
Condom Demonstrations	1270	390	1040	2700
Number of Visits	205	854	88	1147

Practice makes perfect: a community member participating in a condom demonstration.

At the start of 2007, the northeast regional health authority (NERHA) undertook targeted interventions within 12 communities previously reached and added six new communities. The interventions focused on training of peer links, the formation of planning committees for the sustainability of the intervention, as well as the establishment of condom outlets. Baseline surveys were conducted for

communities located in St. Ann. Several planning committees have collaborated with the Behaviour Change Communication (BCC) team to plan health fairs.

Outreach Testing

Almost 10,000 more individuals were tested in outreach testing activities conducted in 2007 when compared with 2006. Scale up was achieved by different methods. For example, the SERHA team trained and certified nine team members as phlebotomists and also ensured that all team members were trained in voluntary counselling and testing (VCT). This was conducted to alleviate the demand for laboratory staff some of whom were not always available for late evening, weekends and public holiday testing events. The Western Regional Health Authority (WRHA) organised its outreach using the theme "Link Up …Get Tested". Testing was conducted at workplaces, special events and festivals such as the Dance Hall Queen, Crab and Coconut Festivals and the Trelawny Yam Festival. Communities and persons attending the entertainment shows have come to accept HIV counselling and testing as a normal activity associated with these events.

Table 7: Summary of Outreach Counselling and Testing in 2007

Region	Number Tested 2006	Number Tested 2007
SERHA	1,691	6,025
WRHA	4,688	6,708
NERHA	1,242	4,744
Total	7,621	17,477

Persons waiting to be tested at a outreach testing activity

Condom Promotion

Beside abstinence, consistent and correct condom use is the best way to reduce the sexual transmission of HIV. Therefore condom promotion and condom skills building should be an integral part of every intervention under the prevention component. Based on reported data from two regions, for each seven to eight condoms distributed, there was one condom demonstration performed. This ratio is inadequate for effective condom skills building leading to correct and consistent use in risky situations.

Table 8: Condoms Distribution Vs Demonstration in Two Regions, 2007

Condom Interventions	SERHA	WRHA
No. of Condoms Distributed	21,573	185,380
No. of Condom Demonstrations Done	2,700	27,133

PLACE

A 26-member outreach team under the aegis of PLACE (Priority Locations for the AIDS Control Efforts) was used to conduct a Randomised Control Trial (RCT), in December 2006. A smaller team of 11 was retained in September 2007 to conduct similar activities while visiting 66 control sites and conducting activities that were undertaken at the intervention sites of the RCT. Some of the 66 control sites were not viable however.

While the team continued to conduct outreach rapid HIV testing at the sites and at special events, the emphasis for 2007 was active recruitment of male volunteers for testing. The team tested 366 males and 341 females. Of those tested, eight males and two females received HIV positive results. HIV prevalence rates remained higher in men than women in both the control and intervention sites. Condom surveys conducted at the intervention sites revealed that of 1,452 persons surveyed during January – June 2007, just 280 (19%) men were equipped with condoms. In keeping with previous findings, significantly fewer women (8%) carried condoms.

Several other activities were achieved by the PLACE team during 2007. The observation phase was completed for a targeted community intervention of an inner-city community in Denham Town. A sub set of the team supported activities for the HIV vaccine trial: This team recruited volunteers with evidence of high-risk behaviour. Although the trial has ended, recruitment was maintained in order to increase the pool of volunteers. This included visits on a weekly basis to the Comprehensive Health Centre in Kingston. Eight members of the team participated in a six-week phlebotomy-training programme and were accredited by the National Public Health Laboratory (NPHL) to participate in conducting testing for HIV at outreach testing sites and at clinics. Training sessions took place between March and July 2007. The National Council on Drug Abuse also conducted training workshops to strengthen the knowledge base about drug abuse. A subset of the team has facilitated the roll out of the intervention in the western region. The team also facilitated other agencies with testing including Children's First and the SERHA BCC team.

Sector & Community Response

Sector ministries entered a new phase at the end of 2007 when the loan agreement (2002-2007) between the Government of Jamaica and the World Bank ended. Five ministries were designated as sector or line ministries in 2002 and were integrated into the National HIV/AIDS/STI Strategic Plan (2002-2006). The sectoral HIV response was constrained by the limited existing staff of each ministry dedicated to the HIV response. The development of an intra-sectoral mechanism for reporting, monitoring and evaluation is also required. Commitment and ownership by each implementing entity is essential for achievement of a successful multi-sectoral response. The following activities were completed during the reporting period:

<u>Ministry of Tourism, Entertainment and Culture</u>

An HIV/AIDS workplace policy for the Tourism sector was launched officially during the year with 200 copies of the policy distributed and a plan to produce 500 CDs. There was a greater endorsement at the highest leadership levels for condom access to stakeholders. Twenty five condom vending machines were

installed in 20 entities. Between April and September 2007, there were 1,225 persons reached through 27 activities. From April 2006- March 2007 through 44 activities, 1,271 persons were reached. Thirty-two (32) activities took place for the period 2005/2006, through which 1000 persons were reached. Approximately 1000 persons volunteered for HIV counselling and testing during outreach testing events.

Ministry of Local Government & Environment

Just about 2, 217 persons were reached through 93 workshops including training in voluntary counselling and testing (VCT) and peer education courses. All the sectoral publics were reached: the Political Directorate, Parish Councils, Jamaica Fire Brigade, Jamaica Women's Centre Foundation, Environmental agencies, and former stakeholders that were attached to Sports and Youth portfolios and Ministry staff. Seven condom vending machines were placed at Women's Centre Foundation locations. Sub Focal Points on HIV/AIDS were designated to act as the responsible officer for the sectoral response within each of 23 agencies. HIV/AIDS corners were also set up at regional offices

Ministry of National Security

Implementation of an HIV prevention intervention to the incarcerated population reached over 85% of inmates and 100% of wards in 12 institutions. Under the project, 246 correctional officers, and 241 inmates/wards were trained as peer educators. Over 100 of them became certified peers. The use of cultural approaches in disseminating information on HIV/AIDS led to a partnership with the Jamaica Cultural Development Commission. This led to success in gold, silver and bonze medals following adjudication by four institutions of items in music, speech, art and drama on a theme related to HIV prevention. Together the institutions gained 167 medals including 60 Gold, 58 Silver, and 49 Bronze.
About 174 officers representing the Jamaica Defence Force, the Jamaica Constabulary Force, the Island Special Constabulary Force, District Constables and Ministry staff were trained as peer educators.

Ministry of Labour & Social Security

Cabinet approved the draft National HIV/AIDS Workplace Policy developed since 2003. The ministry's Life Threatening Illness Manual (which covers HIV/AIDS) was promoted among staff and stakeholders and integrated into existing programmes. The ministry further completed the special research on the socio-economic impact of HIV/AIDS on the Jamaican labour force. During the year, 50 persons trained in voluntary counselling and testing. HIV prevention interventions targeting migrant workers were integrated into the ministry's operational plans. Interventions reached 11,851 migrant workers through 120 sessions between November 2006 and August 2007. The Programme for Advancement through

Health and Education (PATH) is catering to HIV positive persons through negotiation for financial assistance.

Ministry of Education

The Ministry of Education conducted consultations and revised its National Policy on HIV/AIDS Management in Schools. Access to HIV related support material was scaled up through an intervention under the auspices of the Jamaica Library Services through its mobile unit. This made available to students HIV-related texts, brochures and pamphlets. The ministry coordinated the design and broadcast of three anti-stigma and discrimination radio scripts targeting students, parents and teachers. These were aired on three radio stations for two weeks. The strategies of drama and contest were combined in the form of a regional schools drama competition on HIV/AIDS. There were 156 students and guidance counsellors and 93 cultural agents and drama teachers trained in the use of cultural approaches in disseminating information on HIV/AIDS.

Media Relations

Media campaigns were used to complement selected prevention messages. These campaigns covered messages designed for television; radio, print, billboard and bus back panels. Six campaigns were implemented during 2007. Partnership with the media houses has facilitated reduced rates for campaign placements. Some of the smaller television companies will volunteer to air commercials and short films without charge; however the larger companies may just offer a minimal rebate.

Abstinence: "Abstinence Mek Sense" was the tagline used to encourage young persons aged 14-18 years to delay sexual initiation or to "hold off" on sexual activity if they were already sexually active. The first flight (period of three months) was placed in prime time slots of TV stations during December 2006-January 2007. The second flight was aired for two months ending April 2007. The campaign comprised television messages featuring young persons in relatable, familiar looking settings talking candidly about abstinence. It also featured two radio advertisements targeting young men and young women specifically through a DJ/dub performance. The final element of the campaign was print advertising in the form of posters and message panels on bus backs. Analysis of focus group discussions and anecdotal feedback revealed that the target audience found the secondary message "Sex Can Wait" to be more appealing than the use of the word 'abstinence'.

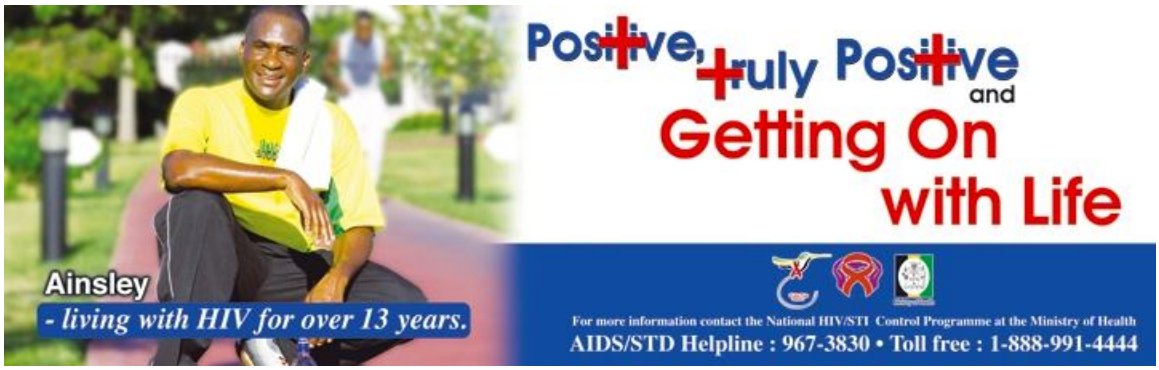
Friends Helpline: The Friends Helpline Campaign ran from March to May 2007 and was developed to publicize the Friend Helpline and the services offered. It comprised messages for television, radio and print (posters, bus back panels).

Adherence to ARV: The adherence campaign that was originally placed in 2005 ran again in 2007. This was in response to the level of attrition being experienced among persons living with HIV and AIDS who were on antiretrovirals. The sole television spot and three radio commercials were placed for a period of six weeks between April and June.

Voluntary Blood Donor Programme: The NHP sponsored the development of a commercial to encourage voluntary blood donation as a means to address the national shortage. The 30-second television commercial followed the storyline of a man riding past the National Blood Transfusion Service (Blood Bank) and suddenly having a thought of what could happen if his son should have an accident and need a transfusion. This thought inspired him to visit the blood bank and donate blood. The commercial was officially launched on World Blood Donor Day (June 14) with the kind sponsorship of media partners.

Voluntary Counselling and Testing (VCT): "Be in the Know. Get tested" was the tagline of the VCT campaign that targeted young adults, especially those embarking on or already in primary relationships. The campaign featured two gender specific television commercials, two posters; one radio commercial aimed at the general population and four billboards. Various media houses sponsored the first flight of the campaign aired between November and December 2007.

Getting on With Life: Placements for TV, billboard and bus panel messages continued during 2007. The campaign began in 2006, featuring two persons living with HIV. Ainsley Reid and Annesha Taylor disclosed their HIV status during anti-discrimination messages. The messages were channelled through radio, television, posters, billboards, bus back panels and fliers. The 'Getting on With Life' campaign was created to help improve accepting attitudes to people living with HIV. Reid and Taylor presented their message while demonstrating that they do the same things other people do. They asked the public to refrain from discrimination. Television messages were aired during the month of January and again during the ICC Cricket World Cup March 5 to April 28 2007. The messages remained on bus back panels and billboards until the end of the year.



IEC Material

Information, education and communication (IEC) material is often used to augment key prevention messages. Among achievements in 2007, the NHP bought the rights to the docudrama "Fi Real" from Dunlop Corbin Communications with absolute power to broadcast and reproduce a video in a broadcast ready format. The docudrama was commissioned by the NHP through consultancy services.

Several booklets were also produced during the year. 'Rude Boy Wayne' is the counterpart booklet to the popular 'Hot Girl Mackiesha'. This booklet is about HIV/STI risk reduction. 'Ann gets tested for HIV' was produced and distributed. It is a low literacy booklet on testing. The story follows a woman named Ann as she makes the decision to get tested for HIV. It also addresses correct and consistent condom use even with regular partners. 'Does Paul have HIV*?'* is a book, originally conceptualised under the title 'My friend has HIV'. This book is also appropriate for persons with low levels of literacy and focuses on some of the cultural barriers that affect the Jamaican population. It also gives information regarding HIV testing and antiretroviral therapy.

Special Events

Special events are used to improve awareness and expose and engage mass audiences. These activities are used traditionally to observe special days and years such as 'Safer Sex Week' in February and 'World AIDS Day' in December.

Safer Sex Week 2007: "Safe Sex/ Good Sex = Rubbers and a Test"

Safer Sex Week 2007 was celebrated from February 11-17 under the theme: 'Safe Sex/ Good Sex = Rubbers and a Test'. The NHP in collaboration with the South East Regional Health Authority (SERHA) undertook three major activities for the week: the Safer Sex Week Launch, all day HIV testing at Nelson Mandela Park and all day testing at St. William Grant Park.

Safer Sex Week Launch, February 12th 2007

'Test the pitch and pad up if you want a good match', stated sportsman and cricketer, Garth Breeze as he lobbied publicly for voluntary HIV counselling and testing (VCT). The importance of condom-use and knowing one's HIV status was highlighted during a special press briefing to launch officially the main interventions focussing on Safer Sex Week (Valentine Day Week). The press launch held each year, took place during February 2007 at the Alfred Sangster Auditorium at the University of Technology.

Safer Sex Week Speaker's Table (L-R) Prof. J. Peter Figueroa, Rev. Patrick Cunningham, Mr Gareth Breese, Howard Hamilton QC

The MVP Track Field Club volunteered for free HIV testing with counselling. Testing tents and VCT staff were on-site in readiness for VCT following the press conference. Olympic Medallist, Michael Frater was among volunteers but he arrived too late to receive media coverage. Other high profile athletes reneged on their commitments but others from the club seized the opportunity to get tested for HIV.

MVP Track and Field Club Olympic Medallist Michael Frater being tested for HIV

Sportsmen as well as journalists and members of the entertainment fraternity have endorsed HIV prevention messages but some sportsmen express a cautious approach in extending further support that may require remuneration.

Nelson Mandela Park, February 14th 2007

Safer sex was linked with messages for Valentine's Day (February 14, 2007) in an HIV/STI risk reduction encounter at Nelson Mandela Park. Teams from the NHP, PLACE and SERHA intermingled with a vast

Condom-use Demonstrations by SERHA Outreach officers at the NHP Booth

audience at the park within an atmosphere of music, dance and live culturally-accepted entertainment. The emphasis however, was on encouraging people to get tested for HIV by choice. HIV testing began as early as nine in the morning utilizing a numbering system and an increased number of testing tents, each with two testers. PLACE DJ Kevin Brooks provided musical entertainment while a steady stream of persons got tested. MC Dahlia Harris quizzed the audience covering the primary modes of HIV transmission, the meaning of HIV and about prevention. Correct answers were rewarded with Valentine themed gift baskets. West Indies cricketer Gareth Breese and Jamaican cricketer Andrew Richardson were on site for their HIV test.

Saint William Grant Park,
February 16th 2007

Prevention messages hit the open air when MC Dahlia Harris prompted the large crowd gathering at the Saint William Grant Park to culminate Safer Sex Week activities on February 16, 2007. The audience shouted back with a mix of slogans from past NHP campaigns: "safe sex, use a condom every time", "no glove, no love", and "live positive" among others. The final Safer Sex Week activity targeted the citizens of down Kingston. Persons arrived as early as 7:30 am waiting in queue to get tested by as early as 9:00am. Partners in the national HIV/AIDS response erected display booths at this event. Linkages to the response were demonstrated in the many booths by Rise Life Management Services, Marge Roper Counselling Unit, of the National Family Planning Board, National Council on Drug Abuse, Hope Worldwide, Jamaica Network of Seropositives (JN+), and the Ministry of National Security with the JCF First Aid Unit. The event was broadcast live by Zip 103 FM from 2:00 to 5:00 pm with Zip Jock Coffee at the helm. Music was provided by Kevin Brooks of Expose entertainment. The participants began dispersing at about 6:00 pm, an hour later than the scheduled closing time.

Young persons listening intently to MC Dahlia Harris

Table 9: Summary of Outreach Testing Activities for Safer Sex Week 2007

Venue	Total Tested	Number Positive	Positive Status Rate
UTECH	79	1	0.76%
Mandela Park	654	5	0.76
Saint William Grant Park	749	16	2.13%
Total	1482	22	1.4%

Policy and Legislative Framework

THE legislative framework for the national HIV/AIDS response at the end of 2007 remained powerless to enforce the much-needed enabling environment for the protection of human rights of the most vulnerable. Notwithstanding, incremental strides to expand policy mechanisms were made through the continuous implementation of the National HIV/AIDS Policy and the Cabinet approval of the National HIV/AIDS Workplace Policy.

In addition, the Ministry of Labour and Social Security (MLSS) continued lobbying for an Occupational Health and Safety Bill to include HIV/AIDS workplace issues. That ministry also implemented and promoted a Voluntary Compliance Programme (VCP) towards the end of 2007 to boost private sector support for HIV/AIDS issues in the workplace. In addition, the MLSS absorbed the four-year ILO/USDOL Education Workplace Programme, which involved 16 large enterprises. Eleven of the 16 entities had developed draft HIV/AIDS workplace policies. The workplace programme financed by the International Labour Organisation and the US Department of Labour ended officially at the end of 2007 and was integrated into the occupational health and safety department of the MLSS.

Although all government ministries had draft workplace policies during 2006, new ministries emerged under the new government administration following general elections in October. This major shift created additional entities to be reached in terms of implementation of HIV/AIDS workplace policies and programmes.

Table 9: Private Sector Commitment to HIV/AIDS in the Workplace 2007

Umbrella Groups	Number of Large Companies (>100 employees)				
	Signed Commitment to ILO Principles	Workplace Programme Established	Workplace Policy Developed	Focal Point on HIV/AIDS Designated	Action Plan Created
Jamaica Business Council on HIV/AIDS (JaBCHA)	21		10	21	3
Jamaica Employers Federation (JEF)	40	40	25	9	
National AIDS Committee (NAC)	23	23	13	15	10
ILO/USDOL Education Workplace Programme	16	16	12	16	16
Total	100	79	60	54	19

By December 2007, there were seven non-line ministries joining the previous five sector ministries as implementing agencies for HIV/AIDS issues. There were also 100 large companies (>100 employees) indicating signed commitment to the ILO Code of Practice for HIV/AIDS and the world of work. Of that number, 79 of the companies had at least a draft HIV/AIDS workplace policy, bringing achievements closer to the target of 90 large companies adopting workplace policies by June 2009.

While the National HIV/STI Programme is leading the implementation of a policy and legislative environment, participation from civil society is increasing. Among achievements is also support from the World Bank to hire a Law and Human Rights Officer to help attain parliamentary accord for supportive law reform. The recruitment and implementation phases involved technical guidance and participation from the resident office of the United Nations Joint Programme on HIV/AIDS (UNAIDS) and the Ministry of Justice through its legal reform department.

Under the workplace policy/programme, staff and stakeholders are sensitised about risk assessment and condom-use skills within the context of HIV/AIDS 101; sexuality and values clarification; non-discrimination through involvement and interaction with people living with HIV (PLHIV); and policy issues within the context of the ILO workplace principles. All workshop participants are assessed through the administration of pre/post tests. Stakeholders are further guided into the construct of an active annual policy work plan.

Public Sector

During 2007 further steps were taken to scale up the participation of the public sector in the national response beyond five line or sector ministries. By the end of the year, five Workplace Programme Officers (WPOs) were hired and attached to a non-line ministry, bringing the total coverage of non-line ministries and their statutory agencies to seven:

- Ministry of Agriculture & Lands
- Ministry of Water and Housing/Transport and Works (2)
- Office of the Prime Minister/Cabinet Office
- Ministry of Mining Energy and Telecommunications/Ministry of Industry Investment and Commerce (2)
- Ministry of Finance and the Public Service

HIV/AIDS workplace policy adoption in the government sector includes:

- An approved Focal Point on HIV/AIDS
- An active steering committee
- An HIV/AIDS workplace policy and an implementation plan
- Sensitised and trained staff and stakeholders
- Trained trainers and peer educators

The following is a summary of achievements within each named ministry or government department:

Agriculture

A permanent employee of the Ministry of Agriculture was transferred on secondment to the post of full-time workplace programme officer. Two support teams were established under this ministry. The ministry created a steering committee and an HIV/AIDS watchdog team of senior management. The workplace policy was approved by senior directors including the permanent secretary. The issue of HIV/AIDS was incorporated into the corporate and operational plans of the ministry with HIV/AIDS issues integrated into the orientation programme for new staff. The ministry participated in Project Smiles - a project for children infected with and affected by HIV and AIDS. The ministry also commemorated World AIDS Day 2007 with the hosting of a ceremony to update attendees about achievements within the year. During the year, this ministry held 33 workshops targeted to general staff, senior management and agencies. The ministry reported that 951 staff and stakeholders were sensitised. Over 4000 male condoms and 22 female condoms were distributed.

Ministries of Water & Housing/Transport and Works

Starting in January 2007, a permanent employee of the Water and Housing ministry continued to work full time as workplace programme officer (WPO). One large ministry had been divided into two separate entities. A steering committee was established, its members sensitised and meetings held monthly. An HIV/AIDS workplace policy was developed and approved by the Permanent Secretary in the former Ministry of Housing Transport Water and Works during May. An amount of 800 employees from the ministry and its agencies have been sensitised. Sensitisation sessions were also targeted to 105 employees in seven internal work units of the Ministry of Water and Housing. Voluntary counselling and testing (VCT) was conducted on request at one of the agencies - the National Works Agency (NWA) in collaboration with the prevention component. Sixty-two employees participated.

The ministry coordinated and hosted 18 one-day workshops that covered 14 agencies, four regional offices and two central offices. The ministry's WPO participated on request in the Pan Caribbean video conferencing held in Jamaica by UWIDITE with eight other Caribbean countries. The discussion focused on the status of HIV/AIDS workplace policies and programmes with Jamaica being considerably ahead of the other countries. The ministry also established systems in relation to HIV/AIDS in the workplace including electronic databases, an information section within the library, journals of media promotions and created a photo album. Other activities throughout the year included a health fair held

during January and the commemoration of Safer Sex Week and World AIDS Day. During Safer Sex Week 1,500 visitors and 300 employees participated in the display and demonstration activities. During the special commemorative week, 1,800 visitors and 800 employees benefited from the viewing of the workplace DVD entitled '*Defend This'*. About 2000 copies of printed material and 600 male condoms and 100 female condoms were distributed were distributed at display booths. The permanent secretary approved financial support from the ministry for design and production of commemorative message novelties.

Office of the Prime Minister/Cabinet Office

A focal point on HIV/AIDS was identified from the Corporate Planning Unit of the Cabinet Office and approved. In June 2007, a workplace programme officer was hired who resigned effective end of November of the same year. The steering committee was revamped and nine workshops were conducted covering 127 employees. The HIV/AIDS workplace policy was revised and approved by Cabinet Secretary and Permanent Secretary in OPM by December 2007. During the period, there was increased support from staff and senior management.

Ministry of Mining Energy and Telecommunications/Ministry of Industry Investment and Commerce

A Focal Point on HIV/AIDS was designated and approved. The HIV/AIDS workplace policy was approved and disseminated within the core ministry and to some agencies. This ministry sensitised 67 members of staff to workplace issues. The annual implementation plan was drafted.

Ministry of Finance and the Public Service

A Focal Point on HIV/AIDS was designated. The HIV/AIDS workplace policy was revised. A Workplace Programme Officer was assigned to this ministry during December. The Steering Committee was established during December.

Ministry of Health

The South Regional Health Authority developed an HIV/AIDS workplace policy. A Focal Point on HIV/AIDS was identified in the central ministry. Twenty-one workshops were conducted dealing with HIV/AIDS in the workplace. The Northeast Regional Health Authority (NERHA) hosted nine workshops and the Southeast Regional Health Authority (SERHA) hosted 12, both working respectively in conjunction with the HIV/AIDS Coordinator (SERHA) and the Regional BCC Officer (NERHA), persons living with HIV and the respective human resources departments.

During the year, one skills-building workshop was held (one-day) for stakeholders during June, which was insufficient for the year. Sixteen stakeholders attended. (See table below)

Table 10: Trainees by Organisation and Job Function

Organisation	# Participants	Type of Participant
JaBCHA	1	Programme Assistant
JEF	1	Workplace Programme Officer (WPO)
NAC	1	WPO
Agriculture & Lands	2	WPO Focal Point on HIV/AIDS
Cabinet Office	2	Focal Point on HIV/AIDS WPO
Panos	1	Journalist
PLWHA	1	PLWHA
Industry Technology Energy & Commerce	2	WPO Focal Point on HIV/AIDS
Office of the G-General	1	Sub Focal Point
SERHA	2	BCC Officers

Next Steps for the Public Sector

By the end of 2008, it is expected that all ministries will have active HIV/AIDS workplace programmes and access to an HIV/AIDS training manual. Workplace programme officers and their focal points on HIV/AIDS have been lobbying for commitment in the budget for a dedicated post to cover HIV/AIDS issues. Such steps include recommendations for a Wellness Centre including HIV/AIDS.

Private Sector and Civil Society

National AIDS Committee

The National AIDS Committee (NAC) began the year with advocacy to high-level leaders. The Executive Director of the NAC recruited 22 lawyers to join the Legal and Ethical Sub Committee, which had been dormant for some time. Officers for this sub committee were elected including a Chairperson and the group met regularly. The team of lawyers offered to provide *pro bono* services for persons needing redress for reported acts of discrimination. The law and human rights arm of the NAC also reviewed existing documents for recommendations about next steps in law reform. Sensitive issues regarding human rights protection for vulnerable groups reached Parliament through the Charter of Rights Bill. Such issues didn't receive unanimous applauses in the House of Parliament, but they were at the very least put on the public agenda.

National Leaders Sign Commitment to HIV/AIDS Leadership Advocacy and Workplace Principles

Prime Minister of Jamaica, Hon. Bruce Golding (L) and Opposition representative, Dr. Fenton Ferguson (R) sign commitment to HIV/AIDS leadership advocacy. Looking on (L-R) Professor J. Peter Figueroa, chief of epidemiology and AIDS; Mr. Phil Green, chairman JaBCHA, UNAIDS country representative in Jamaica, Mrs. Miriam Maluwa and chairman, NAC, Mr. Howard Hamilton

High-level leadership: Prime Minister Honourable Bruce Golding was among 24 high-level leaders and other management personnel who indicated their commitment to HIV/AIDS leadership advocacy including HIV/AIDS in the workplace (Table 11). The leaders signed commitment forms at a Leadership Breakfast held on November 30, 2007 in observance of World AIDS Day. Dr. Fenton Ferguson signed the one-page document on behalf of the Opposition People National Party (PNP).

Seventy-two stakeholders attended the leadership breakfast meeting with 32% participating in the HIV/AIDS survey administered during the registration period. Media coverage of the event focused on the approval of Jamaica second proposal to the Global Fun grant in the amount of US$44 million.

HIV/AIDS Survey Findings: Just 23 of the 72 attendees participated in the HIV/AIDS survey administered during the registration period. About 83% chose the correct responses – the shaded area**.**

		AGREE	DISAGREE
1.	HIV screening is necessary for recruitment and termination of employment.	2	21
2.	An employer has no right to dismiss a worker who is HIV positive to protect other employees.	18	5
3.	Talking with adolescents about sex and condoms encourages them to have sex.	1	22
4.	I would not want my child to attend school with an HIV positive child.	2	21
5.	You should hold the tip of the condom while you roll it down to the base of the penis.	21	2
6.	You cannot get HIV from the saliva, sweat, urine and tears of HIV positive people.	19	4
7.	Only homosexuals are at risk of getting HIV.	0	23
8.	Only persons with more than one sex partner are at risk of getting HIV.	1	21
9.	You can get HIV from oral sex.	17	6
10.	There is currently still no cure for AIDS.	22	1
11.	It is ok for people living with HIV and AIDS to have protected sex.	21	1
12.	You don't have to use a condom with a 'regular' partner.	0	23

The NAC liaised with the Office of the Prime Minister to set the stage for participation in voluntary counselling and testing (VCT) by a high-level leader – the new Prime Minister. As part of commemorative activities for World AIDS Day 2007, Hon. Bruce Golding and his wife, Lorna were tested during a television broadcast. A team from the South East Regional Healthy Authority (SERHA) headed by Regional Behaviour Change Communications Officer, Andrea Campbell, conducted counselling and testing.

VCT with a Smile… Know Your Status

Prime Minister, Hon. Bruce Golding participating in VCT

Capacity Building: Through the policy component, a Finance Officer was recruited to build the capacity of the secretariats of the NAC and JN Plus to handle donor-funding appropriately. A workplace programme officer was also deployed to the NAC.

Workplace Programme (NAC): Guided by the NAC, another 23 large companies signed commitments to ILO workplace principles with 13 of them developing draft workplace policies and at least two having the final approval from their Board of Directors. Within the 23 companies reached, 15 Focal Points on HIV/AIDS were designated, with 10 steering committees established and meeting regularly. Eight of the 13 companies with draft policies had developed a one-year implementation plan.

Table 11: Signatories to HIV/AIDS Leadership Advocacy, 2007

Name	Title	Organisation	HIV/AIDS Leadership Advocacy
Hon. Bruce Golding	Prime Minister	Cabinet	Parliament
Dr. Fenton R. Ferguson	Member of Parliament	Opposition (PNP)	Parliament
Keith Comrie	Assistant Secretary General	Jamaica Confederation of Trade Unions	Civic Society (Trade Union)
Sandra Glasgow	Chief Executive Officer	Private Sector Organisation of Jamaica	Private Sector
Phil Green	Chairman	Jamaica Business Council on HIV/AIDS	Private Sector
Omar Azan	President	Jamaica Manufacturers Association	Private Sector
Madline A. Hinchcliffe	President	Jamaica Employers Federation	Private Sector
Dalma James	Treasurer	Small Business Association of Jamaica	Private Sector
Jennifer Foreman	HR Director	Red Stripe	Private Sector
ICWI Group Foundation	Executive Director	ICWI Group Foundation	Private Sector
Fern Lewis Hue	HR Manager	Jamaica Pegasus Hotel	Private Sector
La'sflo' Bakon	Managing Director	Medimpex Jamaica Limited	Private Sector
Rory Shepherd	Environmental Health & Safety Manager	Sunset Resorts	Private Sector
Lisa Simpson	Environmental Health & Safety Manager	Sandals, Montego Bay	Private Sector
Saharan Walters	Marketing Manager	Island Grill	Private Sector
Alma Chin	Assistant General Manager, Human Resources	RBTT Bank Jamaica Limited	Private Sector
Donovan Perkins	President	Pan Caribbean	Private Sector
David Hall	Chief Executive Officer	Digicel	Private Sector
Kerry Ann Simpson	Assistant Vice President Marketing and PR	First Global Bank	Private Sector
Gerald Coley	HR Manager	Nestle	Private Sector
Roland Campbell	Chief Executive Officer	Capital Credit Merchant Bank	Private Sector
Rhys D. Campbell	Head, Corporate & Regulatory Affairs	CARRERAS Limited	Private Sector
David McBean	Chief Executive Officer	CVM Communications Group	Private Sector (Media)
Karen R. Hilliard	Mission Director	USAID	Donor Agency

Jamaica Employers Federation (JEF)

The Jamaica Employers Federation (JEF) represents the arm of employers in the tripartite relationship with government and workers. It has a membership of over 200 companies of varying staff sizes.

Outputs from the Jamaica Employers Federation (JEF) were not as strong as desired during 2007. The year began with a Workplace Programme Officer seconded from a new position – Occupational Health and Safety Officer - to deal with HIV/AIDS. JEF was expected to follow-up 40 previously reached companies, which generated 27 workplace policies and to court another 20 new companies. At the end of the year, the number of companies reached had not increased. The Federation produced a draft copy of an employer's handbook, which dealt with HIV/AIDS workplace issues and provided a list of agencies dealing with HIV/AIDS as a point of referral. Just four of 15 companies turned up for one workshop hosted by JEF.

The greatest stride recorded during 2007 under JEF was the participation of 18 chief executive officers at a special breakfast session integrated into JEF's executive retreat held at Morgan's Harbour in April 2007. JEF's chief executive officer proposed and pushed this strategy to get management support for HIV/AIDS issues. The session was highly interactive and facilitated the addressing of issues/concerns of employers in relation to HIV/AIDS in the workplace. The CEOs recommended that the insurance sub sector be targeted specifically. Five declaration of commitment to HIV/AIDS in the workplace by senior management were signed at this meeting. Participants received a sensitisation kit including a DVD and CD on HIV/AIDS workplace policy development.

Another milestone for JEF was the process of integrating HIV/AIDS into its annual employers' convention held in May 2007. The 'Getting on With Life' Champion for Change, Ainsley Reid was the keynote speaker for a special luncheon for chief executive officers held at the convention. About 70 CEOs attended that luncheon. Support material was available to the participants including a workplace policy toolkit produced by the NAC and reprinted by JEF. A team from the Northeast Regional Health Authority (NERHA) set up a booth for voluntary counselling and testing (VCT) at the three-day convention and in particular at the Saturday Night Live Party. JEF was also part of the planning team organizing and implementing the special 'Leadership for Life' breakfast held on November 30, 2007.

Jamaican Network of Seropositives

A Board of Directors manages the Jamaican Network of Seropositives (JN+) and the membership is served by a small secretariat. Part of the financing under the Round 3 of the Global Fund grant to scale up prevention, treatment and policy efforts in Jamaica has been used to build the capacity of the secretariat and provide a small stipend for the Board president. This building process however has not improved the functioning of the Secretariat and its fragile relationship with the Board of Directors. During 2007, the secretariat experienced a high level of staff attrition. The Board delayed its annual general meeting until the end of the year. The AGM was used to select and approve a new Board of Directors. The process was observed by the resident UNAIDS office.

Despite the challenges, JN+ contributed to some of the achievements in the national HIV/AIDS response. The organisation led the process of creating and expanding a National HIV-Related Discrimination Reporting and Redress System (NHDRRS). Two forms to capture complaints were created and assessed by a national and multisectoral advisory group of stakeholders. The advisory group also met monthly to develop and revise the system.

Thirty-two reports about discrimination were documented during 2007 with three of the cases referred to *pro bono* lawyers. A website to serve primarily members of JN+ and other persons living with and affected by HIV and AIDS was launched during 2007. Although the website was up and running, 48 deficiencies were noted ranging from typographical errors to major bugs in the coding that runs the system.

At the end of 2007, JN+ had 438 members on its register with over 100 participating in 10 active self-support groups. Thirteen self-support groups were created. During the year 99 claims were approved for the payment of stipend for active participation in prevention and workplace interventions. Persons living with and affected by HIV and AIDS participated in just one skills-building workshops sponsored by the NHP with 17 participants.

Table 12: Summary of Reported Complaints by Month/Setting in 2007

Month	No of Complaints Documented	Setting of Incident	Complaint
January	5	Govt health facility (2), community (2), law enforcement site	Confidentiality breached
			Verbal harassment
			Verbal harassment and eviction notice
			Difficult access to medication and water (inmate)
			Interrogation at pharmacy re payment waiver
February	3	Govt health facility (1), workplace (1), community (2)	Employment terminated at food entity
			Home and community eviction for HIV positive status and sexual orientation
			Physical assault re HIV positive status and sexual orientation
March	3	Workplace (2), community (1)	Social exclusion by community
			Denied access to application for employment based on HIV positive status
April	2	Workplace (1), govt health facility (1)	Refused access to blood based on HIV positive status
May	3	Community (2), home (1)	Social exclusion by community
			Denied access to child by relatives based on HIV positive status
			Privacy breached by peer disclosing HIV status following PLHIV workshop
June	3	Govt health facility (2) workplace (1)	Social exclusion during shopping
			HIV positive status disclosed inappropriately
			Inappropriate comments made to boyfriend of HIV positive person
July	0		
August	1	community	Breach of confidentiality
September	1	community	Social exclusion
October	5	Govt heath facility (1), community (2), workplace (2)	Confidentiality breached
			Harassment/verbal abuse
			Denied access to health care
			Confidentiality breached/forced termination of service
			Forced termination of service
November	6	Govt health facility (2), community (1), NGO (3)	Harassment/verbal abuse
			Harassment/verbal abuse
			Confidentiality breached
			Confidentiality breached
			Confidentiality breached
			Confidentiality breached
December	0		
Total	32		

Getting On With Life: The mass media campaign: 'Getting on with Life' which continued in 2007 having been launched towards the end of 2006, generated accepting attitudes to persons living with HIV and AIDS. The public relations campaign supporting the mass media intervention supported the involvement of PLHIV during face-to-face interventions and during existing television and radio programmes. Feedback of accepting attitudes also increased in the wider Caribbean and international spheres through the engagement of the Caribbean Media Broadcast Partnership on HIV/AIDS and the Kaiser Foundation to broadcast the TV spots.

Ainsley and Annesha were often hailed as celebrities with many people requesting autographs and making physical everyday contact with them. People were seeing first hand that you can't tell by looking who has HIV and that HIV is not transmitted during everyday physical contact. The NHP noted anecdotal references to negative feedback. Some people felt that the campaign gave people the right to get on with life and do anything. The objective of the campaign was to dispel myths and reduce discrimination to PLHIV while strengthening the notion that they have their own lives to live and enjoy. The message recall survey was slated for 2008 at the end of the billboard and bus panel display phase. (*More in the Prevention section*)

Overseas Training: Jamaica participated in a workplace related training workshop sponsored by the Ministry of External Affairs in India. Policy Technical Manager, Faith Hamer from the National HIV/STI Programme and Programme Officer, Julian McKoy from the Jamaica Employers Federation attended the international training programme. It focused on Prevention of HIV/AIDS from January 15 to 25, 2007. The programme which was organized by the V.V. Giri National Labour Institute located in NOIDA, India, attracted the participation of nine persons from South Africa, three from Brazil, three from Ethiopia, two from Bhutan and Jamaica respectively.

Next Steps - Private Sector and Civil Society

In order to expand the coverage to large enterprises the NHP will engage additional workplace programme officers and deploy them to three more umbrella organisations - Jamaica Manufacturers Association, Jamaica Business Council on HIV/AIDS (JaBCHA), and the Private Sector Organisation of Jamaica. Each entity will court at least 20 large enterprises and provide access to office space and equipment. The NHP will also increase the number of skills-building workshops for workplace programme officers, focal points on HIV/AIDS and steering teams.

Table 13: Training Expenditure by Activity and Participant, 2007

Stakeholders	Activity			# Workshops # Sessions	# Participants	Expenditure
	Workshop	Condom Distribution				
		M	F			
Ministry of Agriculture	Sensitisation	4000	22	33	988	413,927.83
Ministry of Mining Energy Industry and Commerce	Sensitisation	-	-	2	67	127,300.00
Ministry of Water & Housing, Transport and Works	Sensitisation	700	100	18	800	1,169,178.71
Office of the Prime Minister/Cabinet Office	Sensitisation	-	-	9	127	216,707.50
Jamaica Employers Federation	Sensitisation	-	-	2	22	59,442.00
National AIDS Committee	Sensitisation	2569	30	12	355	1,270,277.45
Ministry of Health PCU – National HIV/STI Programme	Sensitisation workshops; (NERHA, SERHA; Stakeholders' training workshop)	1275		24	596	872,389.43
Greater Involvement of PLHIV (GIPA)	Involvement in interventions			39	1170	167,386.88
Jamaican Network of Seropositives (JN Plus)	Sensitisation, training			1	9	17,000
	Involvement in response (Claims)			99		466,389.78
TOTAL		8544	62		4134	4,779,999.55

Widening the Multisectoral Response

THE National AIDS Committee (NAC) is responsible for the expansion of the multisectoral response in Jamaica over the past two decades. This growing inter-sector involvement is part of the acceptance testament of HIV as a developmental problem and not simply a health concern. The NAC mobilised the multisectoral response through its National Executive Committee of more than 170 organisations and its five sub committees – Legal and Ethical, Fund-Raising, Education, Committee of Resident International Organisations on HIV/AIDS and Treatment Care and Support.

The NAC also coordinates the Country Coordinating Mechanism (CCM) through which grant proposals from Jamaica to the Global Fund are approved. Alongside the commitment and advocacy through the NAC, was capacity building of 10 organisations to engage in implementation through small grants from the Global Fund. Due to staff attrition, the outputs of the small NAC secretariat were hampered for most of the year.

NGO Collaboration

By May 2007, ten sub recipients received approval for implementation of interventions under the Global Fund grant. Organizations previously contracted were assessed competent based on performance to implement previous interventions in the area of their comparative advantage. The sub-recipients were: Bethel Baptist Church; Combined Disabilities Association; Business and Professional Women's Association; Children First; Jamaica AIDS Support for Life; Ministry of Education; 3D Projects; Joint Board of Teacher Education; and Hope Worldwide. The amounts disbursed are shown in the table below.

Table 14: Sub-recipients and funding amounts for Global Fund Year 3

Sub-Recipient	Funding Amount J$
Bureau of Women's Affairs	426,600
Combined Disabilities Association	3,300,356
Ministry of Labour & Social Security	3,039,960
Family & Parenting Centre	2,489,625
Children First	6,595,820
Jamaica AIDS Support for Life	7,564,592
Ministry of Education	23,786,121
3D Projects	3,918,706
Jamaica Red Cross	4,291,313
Hope Worldwide	4,306,252
GRAND TOTAL	59,719,345

In July 2007, agreements with ten NGOs were documented through signed memoranda of understanding (MOUs). Each pact was for one year ending in May 2008. Highlights of NGO activities by the end of 2007 are outlined below:

The Bureau of Women's Affairs: The project was aimed at promoting gender equality and increasing knowledge among youth about the link between HIV/AIDS and gender-based violence. Youth were also engaged in developing leadership skills to promote behaviour change and HIV prevention. The organization has targeted four high schools in the southeast region and four communities in the parishes of Kingston & St. Andrew, St. Catherine and Clarendon. Up to December 2007, introductory visits were conducted in three of the selected schools, reaching a total of 161 female students and 33 male students.

Combined Disabilities Association: This entity targets persons with mental and physical disabilities as well as community-based groups that provide essential services to the disabled community. The Combined Disabilities Association seeks to provide training in life-skills based HIV/AIDS prevention education. For the period under review, three workshops were held, in Kingston, Portland, and Manchester reaching a total of seventy-six (76) persons with disabilities.

Family & Parenting Centre: The Family & Parenting Centre is the only sub-recipient in the western region and is involved in conducting skills building and prevention education and providing psychological support for HIV positive individuals. Through four workshops the agency reached 42 adults and over 28 children living with HIV. The children received training in basic computer skills, while the adults were counselled on treatment, adherence, nutrition and fitness, disclosure, condom use and dual protection to prevent pregnancy and re-infection.

Hope Worldwide: Using multimedia techniques Hope Worldwide engaged adolescents and youth in interactive risk-reduction education to promote abstinence, and delay sexual intercourse. The organization is implementing its Healthy Lifestyle and ALERT programme in 20 Junior High Schools in the parishes of Kingston & St. Andrew, Clarendon and St. Catherine. Up to the end of 2007, there were 16 of the 20 schools targeted involved in reaching adolescents and youth with the relevant messages.

Children First: Support was provided to the 'Bashy Bus' intervention which is a mobile reproductive health service for adolescents and youth implemented by Children First. The service providers are trained in youth-friendly service delivery enhanced by the use of popular culture. During 2007, interventions were conducted in 10 youth camps, reaching 2,084 adolescents and 146 adults. Fifty-two community interventions were also conducted. These reached 20,503

persons (6,041 adults and 14,462 adolescents) with culturally appropriate sexual and reproductive health information. VCT services were offered to 484 persons.

3D Projects: This project aimed to provide comprehensive sexual and reproductive health services for adolescents/adults with disabilities and their families. The organization focuses on persons with mental retardation.

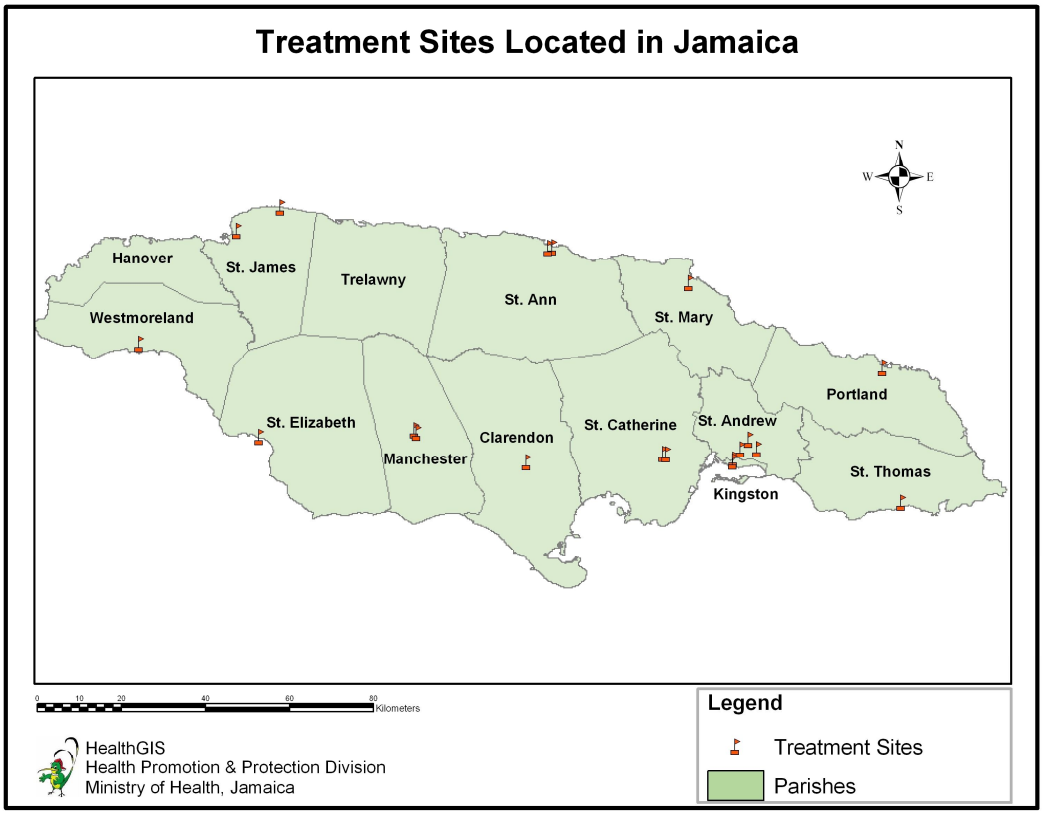
Jamaica AIDS Support for Life: During the year this organization with chapters located in Manchester, Kingston & St Andrew, St. James and St. Ann continued to conduct interventions with vulnerable populations, specifically, targeting men who have sex with men (MSM) and sex workers (SW).

Ministry of Education (MoE): As of September 2007, the revised life-skills based Health and Family Life Education curriculum was implemented in approximately 224 primary and secondary schools. Support was also provided for the recruitment of four Health Promotion Officers in four of the six MoE regions. To prepare teachers for the implementation of the programme 620 were trained in the delivery of the revised curriculum. Over the year the Ministry also reviewed the Strategic Plan for HIV and AIDS for the Education sector, the National Policy for the Management of HIV and AIDS in schools and the National Health and Family Life Education Policy.

Treatment, Care and Support for Persons Living With HIV

JAMAICA has experienced a significant decline in the number of reported deaths due to AIDS. This drop is directly related to the programme of treatment and care for people living with HIV. During January to December 2007, patient care was administered through 19 treatment centres using the multidisciplinary approach. Since the advent of the public access system for antiretroviral medication (ARVs), in 2004, over 3,600 persons have been placed on treatment.

Figure 2



Screening and Diagnostic Services

HIV Testing

The period January to December 2007 showed an increase in the number of HIV tests conducted compared with the year 2006. The number of HIV tests carried out in 2007 was 193,533 compared with 189,959 the previous year. The numbers of tests performed by facility are shown in the table below.

Table 15: Number of HIV Tests Conducted in 2007

Facility	Number of Tests Conducted in 2006	Number of Tests Conducted in 2007
National Public Health Laboratory	12,723	10,514
Private Laboratories	52,289	52,889
Regional Laboratories	81,956	86, 808
Others	42,991	42,322
Total	189,959	193,533

HIV tests were performed mainly within the Regional Health Authorities (RHAs). These were conducted primarily in the antenatal population, where 95 % of women attending the public health facilities were counselled and accepted the test for HIV. The coverage for persons with sexually transmitted infections (STIs) attending clinics and adult hospital admissions is still fairly low and hence represents a missed opportunity.

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

The transmission rate for HIV from mother to child registered at approximately five per cent during 2007. This remarkable achievement (from 25% in 2002) is another indication of progress since the prevention of mother-to-child programme (PMTCT) was initiated in 2003. During 2007, the number of PCR (Polymerase Chain Reaction) samples for early infant diagnosis reached 418, reflecting an almost two-fold increase over the 220 samples for 2006.

Throughout 2007, CD4 tests were conducted at the National Public Health Laboratory (NPHL) and the Cornwall Regional Hospital. Together, the two facilities tested 7,431 samples. The National Public Health Laboratory (NPHL) is still the sole facility providing Viral Load testing, recommended primarily for persons living with HIV (PLHIV) who are on antiretroviral therapy. The laboratory received over 3,400 samples during the year. Both these figures represent a significant increase over the number of samples tested during 2006.

Antiretroviral Therapy (ARV)

ARVs became a feature of Jamaica's public health system during September 2004. By December 2007, the number of persons with advanced HIV placed on ARV treatment reached 3,636. This figure represents 56% of the estimated 6,500 persons that have advanced HIV and therefore require antiretrovirals.

The increasing number of persons placed on treatment is directly related to the reduction in the number of reported deaths due to AIDS. There were 320 deaths attributed to AIDS between January and December 2007 compared to 432 in the corresponding period of 2006 and 514 such deaths in 2005. There were nine cases of paediatric AIDS deaths reported during 2007, compared to 13 and 19 such deaths reported in 2006 and 2005 respectively.

For the majority of 2007, the supply of both adult and paediatric ARVs were consistent. However, at the latter part of the year there were diminished supplies due to several unpredicted delays in receiving new stock. There were no shortages or stock outs of replacement formula experienced at any time during the year. Replacement formula is provided to control the possibility of HIV infection through breast-feeding.

Patients attending private health facilities were still able to access ARVs at markedly reduced prices through the existing Drug Serv Pharmacies. The Health Corporation Limited – the procurement agency of the National HIV/STI Programme (NHP) - supplied these pharmacies. This facilitated private patients purchasing one month's supply of a triple therapy combination at the government prices of just over J$2000/month. The Drug Serv Pharmacies were authorized to fill only those prescriptions written by doctors who had been adequately trained and certified by the combined team of the Ministry of Health and Environment and the Medical Association of Jamaica.

As is the normal practice, the national treatment guidelines were reviewed during the year to ensure that regimens in use were in keeping with internationally accepted standards. Quick reference posters of these updated guidelines were printed for distribution to the treatment sites and private physicians with the kind assistance of the pharmaceutical company Abbott International.

Prevention of Mother-to-Child Transmission (PMTCT)

The success of Jamaica's national HIV/AIDS response is largely reflected in achievements documented by the prevention of Mother-to-Child Transmission (pMTCT) programme. During 2007 more than 90% of pregnant women attending public antenatal clinics received an HIV test. The coverage of HIV infected mothers with antiretroviral medication in some regions decreased in 2007 due to the late presentation of HIV infected mothers coupled with lack of implementation of rapid testing on the labour ward. However, nationally 84% of HIV positive

pregnant women in the public sector received ARV to prevent mother-to-child transmission compared to 74% just two years earlier. Ninety seven percent (97%) of exposed infants received antiretrovirals compared to 87% during 2005. This has resulted in a decline of mother to child transmission. The outputs of the pMTCT programme in 2007 are summarized in Table 16.

The major gap in the pMTCT programme, particularly in the rural areas, is follow-up of the infant especially with regard to conducting blood tests for early diagnosis of HIV status. Different methodologies for obtaining and storing infant blood samples will be investigated to improve access to these blood tests.

Considerable support for the pMTCT programme came from the United Nations Children's Fund (UNICEF). Towards the end of the year, UNICEF provided financial support for nutrition professionals and programme coordinators to build the capacity of the regional health authorities. Additionally, UNICEF provided financing for training and updates in pMTCT throughout the year at the regional level.

Table 16: The PMTCT Programme, Jamaica

	2005	2006	2007**
No. ANC attendees tested	28,651 (96%)	28,446 (95%)	22,478 (95%)
No. ANC attendees HIV +ve	326	470	291
No. of HIV +ve women given ARV	300	371	302
No. of HIV +ve women delivered	401	442	358
Percentage of women getting pMTCT	74%	84%	84%
No. of HIV exposed infants	407	433	362
No. HIV exposed infants getting ARV	353 (87%)	403(93%)	350 (97%)
Percentage of HIV infected infants born to HIV infected women	10%	≈10%	≈5%

** Preliminary data for 2007.

Adherence Programme

Adherence to ARV medication is essential to prevent resistance and other complications. The adherence programme continued to provide support for many clients on ARVs. Social workers and adherence counsellors along with other members of the multidisciplinary team joined forces for this aspect of patient care. Adherence is however affected by socio-economic factors such as unemployment and poverty. It remains a challenge to obtain accurate and reliable measures of patient adherence. This aspect of the programme is being evaluated and revised in order to standardize and improve client outcome.

Medical Management

The NHP collaborated with CHART to host the Annual HIV Clinical Management Workshop over two days during May 2007. More than 180 health care workers from the public and private sectors along with volunteers were trained.

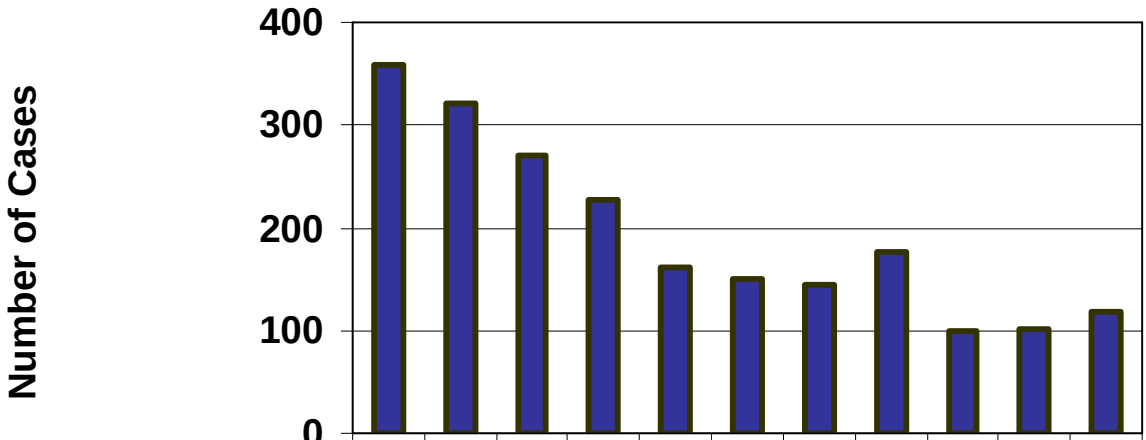
The treatment team, which meets regularly, oversees the implementation of the programme and seeks to ensure the maintenance of basic standards of care. The team supervised the implementation process, reviewed protocols for HIV management and developed and implemented the training programme for all stakeholders involved in HIV treatment, care and support. Other objectives of the group included guiding the testing protocol for HIV and fostering the team

approach to HIV/AIDS Case Management. The NHP continued to supplement the supply of drugs for opportunistic infections (OIs) and sexually transmitted infections (STIs) purchased by the government. Supplies were procured and distributed by the NHP to all regions.

Other Sexually Transmitted Infections (STIs)

Jamaica is experiencing an increase in Syphilis incidence after more than two decades of a downward trend. There was an increase in the number of cases of primary and secondary syphilis in 2007 compared to 2006. See Figure below. Similarly, the number of cases of congenital syphilis also seems to be on the rise.

Figure 3: Number of cases of primary and secondary Syphilis 1997 to 2007



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Primary and Secondary	359	321	270	227	161	151	145	176	100	101	118

The number of STI clinic attendees in 2007 for both males and females also went up compared to 2006. As is the norm more than two times as many females as males sought medical care. Trichomonas was the most common STI diagnosed, followed by Cervicitis. The genital ulcer disease (GUD) demonstrated a downward trend; however, this group of patients represents a key group for transmission of HIV. Herpes was the most common genital ulcer reported but it is also known to be the most misdiagnosed and under-diagnosed GUD and therefore representative of many a missed opportunity to test for HIV. A study performed in Jamaica in 1997 revealed that the prevalence of HIV in patients with GUD was three times that in STI clinic patients in general.

Medical Waste Management

Infection control and the management of medical waste in particular, has been a major challenge for public health care institutions. The problem is further exacerbated by the existence of inactive infection control committees and the lack of posts for infection control officers. Despite the constraints however, the waste management subcomponent has accomplished most of its objectives.

The implementation of the southeast regional medical waste treatment and collection system scheduled for May 2008 was delayed because of Hurricane Dean and general elections during 2007. Data automation and analysis have started in relation to the implementation of proper waste management practices at 15 treatment sites. National guidelines for medical waste management and a code of conduct were prepared and will be printed and distributed following approval by the Chief Medical Officer. Waste disposal supplies and equipment have been distributed throughout the country.

Major Challenges & the Way Forward

The HIV treatment care and support programme should be mainstreamed within health services. However challenges remain that delay this key objective.

Testing: Of the estimated 27,000 HIV infected individuals, it is believed that 18,000 or 67 per cent are unaware of their HIV status. There has been a move internationally to include HIV testing in routine medical care, to offer universal testing in a non-discriminatory fashion. Jamaica has been slow to adopt this practice despite the prompting from the Ministry of Health and Environment in December 2006. Just 15 to 20 per cent of hospital admissions were tested. Other regular clinics including the family planning clinic also had poor coverage.

Confirmation of results was inadequate with long turn-around times for results. Additionally, the standardized database for the capture of HIV rapid testing data was not widely used.

Provider initiated testing of hospital admissions, STI clinic attendees, family planning clinic attendees in both the public and private sector must be prioritized. The incarcerated population must also be included. Outreach activities should be targeted for those most at risk, such as sex workers (SW) and men who have sex with men (MSM).

The provision of a written policy regarding the inclusion of HIV testing as a part of routine medical care should increase the comfort level of health care provider in offering the test to clients.

Treatment: In 2007, more than 3,636 adults and children received antiretroviral treatment in Jamaica. While this number met the target required to maintain

Global Fund support, it was estimated that there were 6,500 persons in need of ARVs and thus the coverage was only 56 per cent. The coverage of persons on ARVs must be improved to achieve universal access targets. 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 at the primary care level while maintaining key referral centres for expert follow up.

Other challenges to the treatment programme include individual adherence to medication, poor sequencing of ARVs, the failure by some physicians to adhere to national guidelines and the lack of access to resistance testing. Research will be conducted to determine the best model for the adherence programme in Jamaica. Training and more frequent updates for physicians will be carried out to keep them abreast of current treatment guidelines. Resistance testing is quite expensive at this point in time however there are early warning indicators that may be monitored and give a fairly good indication of the emergence of HIV drug resistance.

Diagnostic Services: Laboratory services are vital to the success of the national HIV/AIDS response. The National Public Health Laboratory however was heavily dependent on the NHP for funding several aspects of its functioning. The budget of the laboratory was clearly insufficient to cover all the basic HIV services that were offered and as a result service was sometimes inconsistent due to stock out of reagents.

Focus will be placed on building laboratory capacity both centrally and in the regional laboratories. The capacity to perform CD4 and other supportive investigations must be improved. The diagnosis of opportunistic infections will also be given priority. The capacity for resistance testing for TB and HIV drugs will require exploration in view of affordability.

TB Screening: Screening for TB was limited in 2007 due to limited laboratory capacity. Locally there was access to smears only and all samples for culture would have to be sent away to CAREC in Trinidad for processing. This led to very few cultures being done as CAREC was unable to manage the load. Along with limited diagnostic services was inadequate follow up of TB cases on their return to the community and contact tracing.

Linkages between the TB and HIV programmes will be strengthened. Screening all HIV infected persons for TB will be one of the primary outcomes expected. The availability of anti TB drugs will be improved as well as the capacity of the health care workers to deliver decentralized TB care. Work on the TB laboratory will hopefully be completed in 2008 to facilitate the necessary diagnostic tests to support the programme.

Other STIs: Jamaica has practised the syndromic approach to the management of STIs for many years and with significant success. However, there is need for current aetiological data. The most recent prevalence study was carried out in 1995. The management of these conditions must be guided by the evidence. Newly available simple diagnostic technology may make diagnosis of aetiological agents more feasible thus making these tests available to guide diagnosis and management will be the key focus for 2008. The capacity of selected clinics to perform these diagnostic tests will also be a priority.

The STI programme would also benefit from revitalized leadership, starting at the national level and filtering all the way down to the parish level. Empowerment and team work will also be necessary if goals are to be achieved. Contact Investigators have long been an integral component of the STI programme. They have been challenged to achieve their main duty of contact tracing by the fact that the majority of them have competing clinical duties. Along with increasing the cadre of this category of worker, the role of the Contact Investigator will have to be reviewed with a view to improving the output.

Waste Management: The draft of the National Medical Waste Management Policy defines the rationale for healthcare waste management and what the Ministry of Health and Environment wants to achieve. The draft policy will be submitted to Cabinet for approval, followed by the development of a strategic plan, including a legal and regulatory framework. It is integral to get parliamentary acceptance for a new Medical Waste Management Act as proposed in the draft policy. Also outlined in the policy is the development and implementation of a licensing system as well as a Manifest and Tracking System for transportation of medical waste. Stakeholders include the National Solid Waste Management Authority, the National Environment Planning Agency and the Ministry of Health and Environment.

During 2007, there were several barriers which affected the completion of the specific objectives of the work plan. Among the barriers were the lengthy procurement process, unavailability of waste disposal supplies, slow response to waste management initiatives and resource constraints of healthcare facilities and regional health authorities. The following represents the way forward:

1. Annual budgets should be allocated for waste management and infection control
2. Regional health authorities (RHAs) and individual health care facilities should include waste management on their annual work plan.
3. Regional health authorities should make the necessary recommendation to the manpower development division for the creation of posts for infection control officers.
4. Other stakeholders need to participate in waste management and infection control such as the Ministry of Finance and the Public Service, the National Environmental Planning Agency, and the National Solid Waste. This collaboration will assist the Ministry of Health and Environment in developing and getting approval for protocols and guidelines

5. The MOHE should develop and institute a centralized procurement system for waste disposal supplies and equipment, particularly biohazard 'red' bags, step-on bins, sharp containers and personal protective clothing for waste collection workers. Alternatively, the latter should be included in the contracts of the companies providing sanitation services.

Stigma and Discrimination: Despite improved accepting attitudes to people living with HIV, stigma and discrimination blocks VCT, regular care and disclosure of HIV status to partners and families. An expanded support netwrok offerin redress is needed.

Human Resources: Health facilities do not have the required number doctors, nurses, social workers, nutritionists, pharmacists and others for effective coverage. In addition, staff attrition has affected outputs.

Positive Prevention: Positive prevention programmes that involve PLHIV must be developed and implemented and should cover issues about the protection of human rights. These should be mainstream and integrated into treatment and prevention programmes. It is planned to train adherence counsellors to deal with positive prevention strategies.

Psychosocial Support for PLHIV: In general, there is a significant lack of easily accessible social support services. Social issues however, impact on the health outcome of PLHIV very severely. PLHIV require empowerment to facilitate greater self-care. The government alone cannot provide the entirety of services required and therefore this support will have to be provided through partnerships with non-governmental organisations (NGOs), the private sector and other members of civil society.

Monitoring and Evaluation

THE Monitoring and Evaluation (M&E) unit had a central and integral role in tracking and analyzing the HIV epidemiological profile of Jamaica. The unit also prepared indicators, targets and population size estimates to help the National HIV/STI Programme (NHP) develop new proposals and review past experiences. The year 2007 was particularly challenging as the NHP began a new strategic plan, on HIV/AIDS/STI while still in its draft format. Furthermore, the national programme completed its five-year Government of Jamaica/World Bank loan agreement and approached the final year of Round Three of the Global Fund Grant. This resulted in a bevy of activities including end of project reports, writing proposals for Round Seven of the Global Fund grant and another proposal for the World Bank follow-on project. Of equal importance was the finalization of the Monitoring and Evaluation (M&E) plan.

Three priority areas kept the wheels of M & E in motion throughout 2007: (1) to refine the M & E system during stakeholder consultations (2) to develop data collection tools and (3) to implement computerized data systems including an electronic medical record. The execution of the activities under these priority areas were funded by three main sources: the Government of Jamaica, the World Bank through a loan agreement; and grants from the Global Fund and the United States Agency for International Development (USAID). Successful performance of the NHP is demonstrated by the achievement of agreed donor specific, national, regional and international indicators. Global Fund and World Bank indicators are summarized below.

Table 17: Global Fund Indicator report (September to November, 2007)

Indicators	Baseline	Year	Targets	Actual Results
Number of individuals receiving CD4 tests, in accordance with guidelines	0	2003	15,589	16,303
Number of infants born to HIV+ mothers receiving PCR testing according to national standards	0	2003	500	717
Number of PLWHA receiving adherence counselling	0	2003	3500 Adults	3,636
Number of adults and children with advanced HIV receiving ARVs	50 Adults 0 Children	2003	3200 adults 285 children	3300 adults 336 children
Number of Sex Workers/MSM reached through prevention activities	300 CSW 300 MSM	May-05	4270 CSW 6547 MSM	7386 MSM 6083 CSW
Number of service deliverers trained on HIV/AIDS Prevention	125	2003	400	625

Table 18: World Bank indicators, project period 2002 – 2007

Target Population	Indicators and Targets	Actual
Prevention programs targeted at high-risk groups and the general population		
General Population and High Risk Groups: ANC Attendees, army recruits, CSWs	IMPACT: HIV Prevalence among: -ANC Attendees 15-24 yrs remains below 2% - army recruits remains <1% -CSW HIV prevalence decreases from 20%-10% in Montego Bay - HIV prevalence reduces from 10% to 7% in Kingston	 1.5% (2005) 0.69% (2007) ; 9% (2005)
	<u>OUTCOME</u> -Reduce median age of first sex by at least 0.5 years	M: 15.7 (2004) F: 17.2 2008 KABP pending
	-% of men/women 15-49 yrs who report using a condom in their last sexual intercourse with a non-regular partner, increases in men from 76% to 85% and in women from 66% to 75%	 M: 74% (2004) F: 66% 2008 KABP pending
	% ANC attendees who test for HIV increases from 15% to 80%	96% (2005); 95% (2006)
CSW	% CSWs who report using a condom with last client increases from 75% to 85%	Tourist /client -90.1%, Jamaican/local client - 92.4% (2005)
PLWHAs	<u>OUTPUTS</u> National guidelines for OI management developed	Completed
	Turn around time for HIV testing reduced to 7 working days or less if negative and 14 working days if positive	Achieved
	100% of health districts have at least one trained counsellor providing VCT counselling	Achieved
	Completion of computerization for: -NPHL -Nation Blood Transfusion services -surveillance system -M&E Unit databases in the MOH and Regional Authorities -drug inventory nationally and at regional treatment centres	LIS being implemented; M&E database being developed and implemented
	Annual project funding disbursed by RHAs and parishes for activities increases annually over the life of the project	Achieved
M&E Units including information platforms	Recurrent second generation surveillance of -general population -vulnerable populations	Achieved (sentinel surveillance and KABP, CSW survey)

M & E Plan/System

An M&E plan for the national HIV/AIDS response was finalised during 2007. The M&E unit set up the main system for tracking and assessment during (1) stakeholder consultations on the M&E plan and core indicators, (2) training of stakeholders in basic M&E concepts and use of data collection tools, and (3) development of data collection tools including databases. After a series of workshops, the first final draft of the M & E plan was compiled. This included identification of a set of core indicators with baselines, where available, and agreed upon targets. These indicators were consistent with the new strategic plan (2007 to 2012) and were formulated after consultations with the Jamaica Monitoring and Evaluation Reference Group (MERG). The M&E framework was summarized in the M&E plan and the detailed components of the system were described in a companion document, the M&E operations manual. This manual was also drafted in 2007. Both documents and stakeholder consultations were facilitated by technical assistance form the MEASURE team of University of North Carolina, through USAID funded support. The draft M&E plan is available at the NHP website.

Stakeholder Training

The M&E unit also participated in several training activities and workshops in order to strengthen the capacity of stakeholders to conduct M&E and to integrate various data collection ventures. The core training material and instructions were integrated into existing workshops and a series of workshops organised by SERHA. The SERHA workshops were aimed at equipping health care workers involved in HIV care with a better understanding of M&E and their role in data collection and utilization.

Stand-alone workshops were conducted to train relevant stakeholders in the use of the electronic treatment register. Consultations were also organised for stakeholders to become familiar with the JAMSTATS database. The process was about absorbing into the database, all HIV indicators used by the NHP and the Ministry of Health and Environment. This included the identification of the indicators, review of reference sheets for all indicators involved and submission of baselines where available.

A special workshop was organised for contact investigators (CIs). This provided a forum for discussion of critical issues pertaining to CI data collection, HIV surveillance, and STI monitoring. Forty-five contact investigators attended and discussions focused on the importance of standardized case definitions and reporting forms. The revised Confidential HIV case reporting form was reviewed and findings of 2005 analysis of STI data were presented. This should improve the system of reporting from contact investigators to include timely and accurate

reporting. Also needed is increased supervision of contact investigators through the designation and recruitment of a Senior Contact Investigator.

Overseas training was provided in the form of participation in the New York LINK/Universal Access Training and Professional Exchange Programme from June 22-June 28, 2007. This training programme was a technology transfer and resource exchange project that focused on strengthening national targets to meet "Universal Access", as defined by the Millennium Development Goals. The NYLINK provided strategies for National HIV/AIDS programmes to strengthen prevention and treatment care and support programmes. Strategies included an overview of best practices in prevention (e.g. Empirically validated interventions in the U.S. and effective strategies from other Caribbean countries) and best practices in treatment, care and support (e.g. protocol for the home based care training programme in Guyana, adherence interventions and mental health interventions for PLWHA).

Another training opportunity helped participants understand the link between research findings and the formulation of policy. This workshop focused on bridging the research/policy gap. It also assisted participants to better understand how research findings can be utilized to inform the policy process, as well as to develop an understanding of the elements of a communication plan. A major focus of the workshop was also on developing a communication plan and learning practical techniques for working with the media to deliver specific messages.

There was also training on 'Methods for Estimating and Projecting HIV/AIDS Epidemics and its Demographic Impact', held in Port of Spain, Trinidad and Tobago. Training activities focused on three main softwares - Workbook, EPP and Spectrum. 'Workbook', is an Excel-based spreadsheet that allows for input of population and prevalence estimates of high risk groups and their partners and/or ANC clinics data. With these inputs, the tool provides a country HIV prevalence estimate and projection. It also provides output that is used in Spectrum for projections. The Estimation and Projection Package (EPP) uses ANC data and helps us define the national epidemic in terms of relevant sub epidemics: Urban & Rural.

Gender in M & E

Maintaining gender-sensitivity was the focus of a gender consultation. This meeting was geared towards the mainstreaming of gender sensitivity while ensuring that appropriate indicators were identified and included in the M&E plan.

HIV/AIDS Module

The M & E unit collaborated with the Planning Institute of Jamaica (PIOJ) on the development of a HIV/AIDS model. The process entailed refining the HIV/AIDS

module of the T21 model. The HIV/AIDS module describes the main forces that drive the growth and decline of the HIV epidemic in a country. The process entails tracking demographic changes, sexual behaviour patterns of the population and government policies targeted at treatment and intervention. The team identified and defined major assumptions of the module such as proportion of HIV infected persons that practice unsafe sex, number of sexual contacts made per HIV infected persons, probability of unprotected sex between an infected and an uninfected person, and infectivity rate per sexual contact. The model is a work in progress and requires additional behavioural data, which will be garnered from ongoing surveys of high-risk populations.

Discrimination Reporting and Redress

The NHP was represented by the policy component and the M & E unit on an advisory group considering a national system to address discrimination complaints and its redress. The body worked on a national system to document complaints about discrimination and integrating redress into existing systems. The core function for collecting and documenting complaints is coordinated by the Jamaican Network for Seropositives (JN Plus). Other members of the advisory group are UNAIDS, NAC, and the Independent Jamaica Council for Human Rights (IJCHR). The advisory group prepared a document explaining how the system of discrimination reporting and redress would operate. The M & E Unit assisted JN Plus in developing the database which documents the reported cases.

M & E and TB/HIV

The M & E Unit also cooperated with the Ministry of Health and Environment's surveillance team and the Pan American Health Organisation (PAHO) in developing the monitoring and evaluation component of the National TB (Tuberculosis) Programme including the identification of TB and TB/HIV indicators.

Development of Data Collection Tools

Tracking of reports received in 2007 emphasized the lack of regard for timely reporting. Stakeholders (excluding line ministries and CHART) failed to send in more than 50% of reports on time for any reporting period (July to August 2007 reports summarized below). This pattern was observed throughout the year and hindered timely generation of summary statistics and data utilization for programme planning.

Table 19: Numbers of reports received from stakeholders July to August

Report Source	Expected	July to August		
		On time[a]	Late[b]	Missing[c]
Contact Investigators	26	2	5	19
STD Clinics	26	2	6	18
Line Ministries	10	0	0	10
Sub recipients	26	0	0	26
CHART	2	1	0	1
PAAs	26	0	0	26
Quarterly Regional Report	4	1	-	3

Under reporting was also evident in various sectors including HIV case reporting. For example, among persons with advanced HIV attending treatment sites (who applied for National Health Fund cards), 25 to 40% were not reported to the Ministry of Health and Environment. This has important implications for surveillance and indicate the need for wide spread sensitisation.

Table 20: National Health Fund application forms received

Date Received	Total Forms Received	Total not on HATS (%)
March 12, 2007	34	10 (29)
March 26, 2007	53	13 (25)
May 24, 2007	22	9 (41)
June 19, 2007	19	6 (32)
July 6, 2007	15	5 (33)
July 24, 2007	15	6 (40)
August 8, 2007	8	1 (12)
August 21, 2007	57	18 (32)
September 18, 2007	12	5 (42)

Special Studies and Surveys

In 2007, some special studies and surveillance were conducted. This included sentinel surveillance of antenatal clinic (ANC) and STI attendees, the national composite policy index and the survey of financial resources. The Joint United Nations Programme on HIV/AIDS (UNAIDS) provided financial support to conduct the policy index and the financial survey. UNAIDS also provided support to enable data gathering for the UNGASS reporting. The trend analysis of the National Composite Policy Index (NCPI) is found in the 2008 report to UNGASS. The final report on the financial flow survey is pending.

KABP: During the latter part of 2007, discussions and planning for the next Knowledge Attitude Behaviour and Practices (KABP) ensued. The survey instrument was drafted and reviewed to ensure inclusion of all relevant indicators. The survey was planned to be conducted in January 2008.

High Risk Groups: Review of instruments and methodologies for survey of high risk groups including sex workers (SW) was also conducted in 2007 and these will be implemented in 2008. The findings of the randomized controlled trial comparing low and high intensity prevention interventions were presented in 2008 and revealed no difference in outcomes between both groups.

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. These reports and other findings of the M&E system are presented at conferences and workshops, including the annual review of the NHP. The findings are also posted on the NHP website, and published (e.g. Epidemiology updates and UNGASS report). Some reports that were generated in 2007 include:

- 2006 to 2007 UNGASS Report
- AIDS epidemic update (annual report in progress)
- PAHO –universal access report
- PAHO – treatment update
- PAHO DC – Country report on AIDS cases 2004 -2005
- Poverty eradication report for Ministry of Health
- Section on HIV for health chapter of Economic and Social Survey, PIOJ
- JASPEV report
- Report to donors including World Bank and global fund
- MOH and NHP 2006 annual report
- CAREC report
- CHRC data collection project

The National Strategic Plan 2007-2012 prepared by NHP was reviewed and edited in-house based on recommendation of the PEER review (UNAIDS). All reports are available on request. .

Computerized Data Systems Including an Electronic Medical Record

The M&E information technology staff continued to offer technical support to the National Public Health Laboratory (NPHL), the surveillance unit and the Kingston & St. Andrew Health Department. Databases were updated and implemented as highlighted: , the team continued efforts to improve the information system by updating and implementing databases, which are highlighted below.

HATS: In 2007, the upgraded HATS was used for generation of statistics for the 2007 Epi Updates. Additional steps were made towards implementation of the web-based HATS. This includes purchase of hardware (computers and network cards) to support implementation of the database, configuration of HATS for wide area access, remote testing of the database, and training of two key personnel on the Citrix software (from SITU and the M&E unit). SITU is overseeing the implementation of the Citrix software, with M&E support.

Rapid Test Database: Revisions of the database was completed and eight additional computers were procured to support implementation. The backlog of rapid test data was entered in some regions due to M&E support. However some regions (SRHA and WRHA) had difficulty operationalizing plans to enter this back log (reasons unclear).

M&E database: This database was designed and used in 2007 for collating various reports received at the M&E unit. The reports entered include:

- Regional progress reports
- Stakeholder reports (sub-recipients, PAAs, regional health authorities)
- BCC reports
- Contact investigator reports
- Laboratory reports

HIV electronic medical record (EMR): The database manager met with staff from Comprehensive section 3 to discuss the requirement for an HIV EMR and the existing database was modified accordingly. Computers were procured and installed in preparation for the database, which will be implemented in 2008.

HIV electronic register: The HIV electronic register was installed at all treatment sites and computers and printers were delivered (except to National Chest Hospital where finding appropriate space is a problem). This register will allow tracking of persons on treatment and reporting of indicators such as survival of persons on ART. Island-wide retraining on use of the database was done and persons were identified to update the database.

Challenges and the Way Forward

During 2007, there was some progress, but not enough to make the M&E system operate efficiently. Late and incomplete reports result in inaccurate data and delay generation of products. Two members of the team resigned – the Biostatistician and a Data Entry Clerk.

The M&E plan will be implemented during 2008. This includes dissemination of the plan and the operational manual. Training will continue to build the capacity of stakeholders to understand and use basic M&E concepts and data collection tools. The M&E team will ensure that data collection tools are refined to meet reporting requirements. Databases will be implemented such as the web-based

HATS, the electronic medical record, the M&E information system and the HIV treatment database. Also on the table for 2008 is the development and implementation of a research agenda. This will inform the NHP of the priority areas and the successes and failures as far as interventions are concerned, and the way forward. The NHP will continue to work with donors, international and regional agencies to further harmonize indicators.

Health Systems and Capacity Development

THE Health Systems and Capacity Development component directed efforts during 2007 to strengthen the readiness of stakeholders to assist with the national HIV/AIDS response. This entailed buttressing the capacity of implementing partners to sustain their participation in the national response in accordance with the national strategic plan 2007–2012. This component covers:

- Improved diagnostic capacity of service delivery which means improvement in the confidence and reliability of the HIV testing mechanism;
- The establishment of treatment centres;
- Implementation of a Laboratory Information System at the National Public Health Laboratory (NPHL); and
- Planning, management and implementation capacity of the national programme and its major stakeholders

The priority for 2007 was to increase the capability of health facilities across the island to deliver appropriate care to persons infected and affected by HIV. The focus was on completing major activities started in 2006 including the implementation of the Laboratory Information System (LIS) at the National Public Health Laboratory (NPHL), and completion of the treatment sites in the Western, Southern and North East health regions. During 2007, revisions were made to the draft National Policy on Blood following workshops with stakeholders. The final draft will be submitted to Cabinet for approval.

Civil Works

Structural renovations began for more than 21 health facilities located throughout the island which are designated as voluntary counselling and testing sites or treatment centres. These centres contribute significantly to improving patient care and laboratory functions. During 2007, construction work at three treatment sites was completed utilizing financial resources provided under the Government of Jamaica/World Bank loan agreement. The St. Ann's Bay Health Centre and Savannah-La-Mar Hospital were fitted with additional examination rooms which increased their capacity to serve patients effectively. The general patient waiting area of the Savannah-La-Mar Hospital was expanded creating a better environment for service delivery and facilitating better patient flow. At the Mandeville Health Centre, an office area for public health inspectors was established as well as a multi-functional storage area. The storage area was constructed to enable changes in the future and can be converted to provide additional conference facilities/office space if necessary. For the most part, civil

works were delivered later than scheduled. Despite this, health facilities have increased the capital stock of the health sector.

Savanna-La-Mar Hospital

Mandeville Health Centre

Completed storage area

Completed Office area

St. Ann's Bay Health Centre

Picture to be inserted

Laboratory Information System

The contract for the Laboratory Information System (LIS) was signed during March 2007. The contract was awarded to the USA-based firm, Starlims, which supplies Laboratory Information Systems internationally. This is the firm's first installation in the Caribbean. The contract will result in the installation of the LIS inclusive of a module for the Blood Bank at the National Public Health Laboratory, the Emergency Laboratory at the Kingston Public Hospital, the Comprehensive Health Centre (CHC) and the Victoria Jubilee Hospital (VJH)

Cross Match Laboratory. The LIS will facilitate the automation of tracking samples throughout the NPHL. In addition the three other facilities will be able to track samples sent to the NPHL. Barcode technology will be used to track the samples to promote the reduction in medical errors, streamline workflow and accountability and enhance the ability to identify specimen/samples throughout the laboratory process. This will facilitate among other things, monitoring of the timeline from sample receipt to result generation in order to improve efficiencies in the laboratory. The LIS will allow consultant physicians at the CHC, VJH and KPH to access laboratory results by (1) viewing them on the LIS within the labs (2) through messages sent directly to their email or (3) from hard copies. The entire process will be automated allowing laboratory testing equipment to interface with the LIS to produce results without manual intervention.

The LIS and the Blood Bank module were scheduled to be completed by December 2007 but the end phase had to be postponed until February 2008. The design of the Blood Bank module took longer than expected. The prototype LIS was installed at the National Public Health Laboratory and initial training completed by June 2007. Configuration of all the modules was completed in October. The other activities undertaken at the NPHL to facilitate the implementation of the LIS included the installation of Unlimited Power Supply units along with electrical works, the rehabilitation of the air handling system, the purchase of temperature monitors and the purchase of SQL software.

Tuberculosis Laboratory

To facilitate the reopening of the TB laboratory at the NPHL, the process was initiated to hire a consultant to inform the installation of an air-conditioning unit and undertake minor civil works. The evaluation and recommendation for contract award were completed at year end with the contract award awaiting final approval.

Medical Equipment

Several items of medical equipment including disposable items, centrifuges, examination tables, diagnostic sets, microscopes, rotators and sphygmomanometers were provided to health facilities across the island.

Capacity Building

Non-governmental organisations (NGO) were equipped with policy and procedural manuals. The documents offered guidance in operations, human resources, accounting and information technology. The manuals represented the second phase of a consultancy which began in 2006. The consultancy was aimed at improving service delivery and accountability as well as addressing the issue of sustainability. Workshops were also held for Board members and staff of NGOs to provide training in the areas of staff development, governance and financial administration. The consulting firm designed the relevant training modules. The consulting firm also identified the NGOs most likely to benefit from the intervention. The selection was based on information gathered during the

needs assessment phase. Six NGOs were selected. Staff members from Parish AIDS Associations (PAA) were also nominated to participate in the training. All the NGOs selected were beneficiaries of grants from the Global Fund. The training programme covered other subjects such as Information Technology, an introduction to Strategic Planning, Basic Accounting and Management Reporting. The training programme also comprised an extensive review of the new Companies Act and this was offered specifically to NGO board members and management teams.

ERTU-CHART

CHART Jamaica (Caribbean HIV/ AIDS Regional Training Network) is one of the national training centres of the CHART Network. As it is associated with the Epidemiology Research and Training Unit (ERTU) it has come to be known as ERTU-CHART and therefore falls under the umbrella of the Ministry of Health and Environment. The objectives of ERTU-CHART are:

- To determine the training needs of NHP and other key stakeholders;
- To conduct training for health care workers and others;
- To monitor transfer of learning and address the deficiencies where possible;
- To further develop ERTU-CHART as a training resource centre.

During 2007 numerous needs assessment surveys were conducted to determine the training needs of the NHP and other key stakeholders. The draft work plans from the Regional Health Authorities and the National Strategic Plan 2007-2012 were used to develop the training plan for the year. The needs assessments were not confined to the public sector only as the Association of General Practitioners also benefited from these activities. During 2007, CHART deviated from its usual training strategy covering the Treatment & Care component and included the Prevention component. The capacities of staff involved in Behaviour Change Communication (BCC) were strengthened to deal with issues of self-efficacy, risk reduction, gender sensitivity and basic BCC conversations.

With the advent of PITC, there was need for clarity regarding the role of VCT. CHART held a meeting to ascertain the way forward with respect to co-existence of methodologies, service delivery, regional coordination and monitoring and evaluation of services. The unit also assessed its own training needs. Next steps include locating funding for training and identifying the most suitable institutions.

Training workshops conducted for health care workers and others stakeholders are summarized in Table 24. In addition to those listed, CHART also collaborated with other entities to conduct workshops including RHAs, private sector, the University of the West Indies and University of Alabama and United Theological College. Technical assistance was also provided through equipment and planning for local training workshops.

Table 21: Training conducted by CHART in 2007

Type of Training	Number Conducted	Category of Staff	Topics
Workshops	22	Physicians, Nurses, Midwives, CPEs, CIs, Public Health Students	Management of HIV/ STIs, VCT, M&E, Medical Waste Management
Preceptorships/ Observership	9	Medical students, Physicians,	HIV/ STI
Sponsored Courses	4	Physicians, Public Health Doctors MOs(H), Trainers	HIV Management, M&E
Mentorship Training	2	Physicians, Nurses	
Staff Retreat/ Capacity Building	1	ERTU-CHART team	Team building, stress management
Pre-service Training		Medical students, Public Health students	HIV/ STI
Trainers' Updates	4	Advanced Trainers, trainers	Instructional Design, mentorship, VCT Training

Table 22: Participant Count by Training Focus – May and December 2007

Training Focus	Participant Count
Counselling	1741
ART	149
Policy Analysis & System strengthening	190
Laboratory	0
pMTCT	92
Strategic Information	30
Prevention	109
Palliative	176
Other	159
TOTAL	2646

Monitoring and evaluation was given priority attention. Interventions included evaluation exercises. Training sessions were designed to incorporate the evaluation exercises while PQI assessments were conducted at VCT sites. Following two meetings with teams from RHAs, the PQI Assessment Tool was modified. Participants expressed concerns about the fairness of the scoring system used.

One indicator used to measure the success of ERTU-CHART as a training resource centre was the number of training materials collected for distribution. Some of these are shown in the table below. Other materials such as pens, folders and jump drives were also distributed.

Table 23: Training material distributed

Material	Number Collected
Adult HIV/AIDS Treatment Guide	81
STI Vade Mecum	312
ARV Pocket Guide	298
CAREC Caribbean Guidelines CD	3
Carec Guide to Opportunistic Infections, 2005	275
Practical Case Management of Common STI Syndrome	29
Management of STIs	59
VCT Reference Manuals	91

Challenges and Constraints

There were many challenges experienced during 2007. Scheduled activities had to be postponed because of curriculum issues, inappropriate date and time and national and natural events such as general elections and hurricanes. Events that were affected included the TOT requested by GHARP in Guyana, the Syndromic Approach to STI Management, the Clinical Preceptorship at Comprehensive Health Centre and the Medical Waste Management workshops.
The preceptorship programme scheduled for CHC has been affected negatively by a heavy case load, competing public health priorities such as the malaria outbreak and a general staff shortage.

The training of new individuals to join the diminishing pool of Contact Investigators was delayed yet again by human resource issues. All the Regional Health Authorities were not able to identify vacant posts in which to place their recruits.

Other challenges include a general paucity of resources for dissemination. Due to lack of funds, CHART RCU was unsure of when additional resources would be provided.

Best Practices/Lessons Learned

Conducting preceptorship at the treatment sites worked well as this facilitated the participation of an increased number of doctors and allowed them to review their cases e.g. the Medical Director went to Cornwall Regional Hospital and Savannah-La-Mar la mar Health Centre.

Expanding the administration of needs assessment surveys within workshops carried out by Regional HIV/STI Coordinators and outside of CHART's timetable allows for more data to be collected.

A mini assessment of the positive prevention efforts and care offered at the treatment sites using the "Treatment Journey" methodology used by The Alliance was conducted by a consultant. PLWHAs that participated in the focus group sessions voiced some of their concerns during group meetings at the NHP HIV Management workshop. This provided an opportunity for discussion about care between providers and clients. One issue that was highlighted was the lack of information provided by providers on other contraceptive methods besides the condom.

ERTU-CHART participated in the monthly I-TECH Distance Learning Seminar Series. Brief case discussions were sometimes held with the audience present, thus lessening the need to assemble treatment site teams for monthly case presentations.

Research

The following studies were conducted during the year:

- Seventy two women between the ages of 16-35 years were recruited for the Contraceptive Prevalence Feasibility Survey completed in early April. There was a high prevalence of chlamydia among female clients.
- A Master of Public Health student conducted a survey among clients on ARVs at CHC during the month of March.
- An article on PMTCT and contact investigation was prepared by the Medical Director and some Contact Investigators for WIMJ.

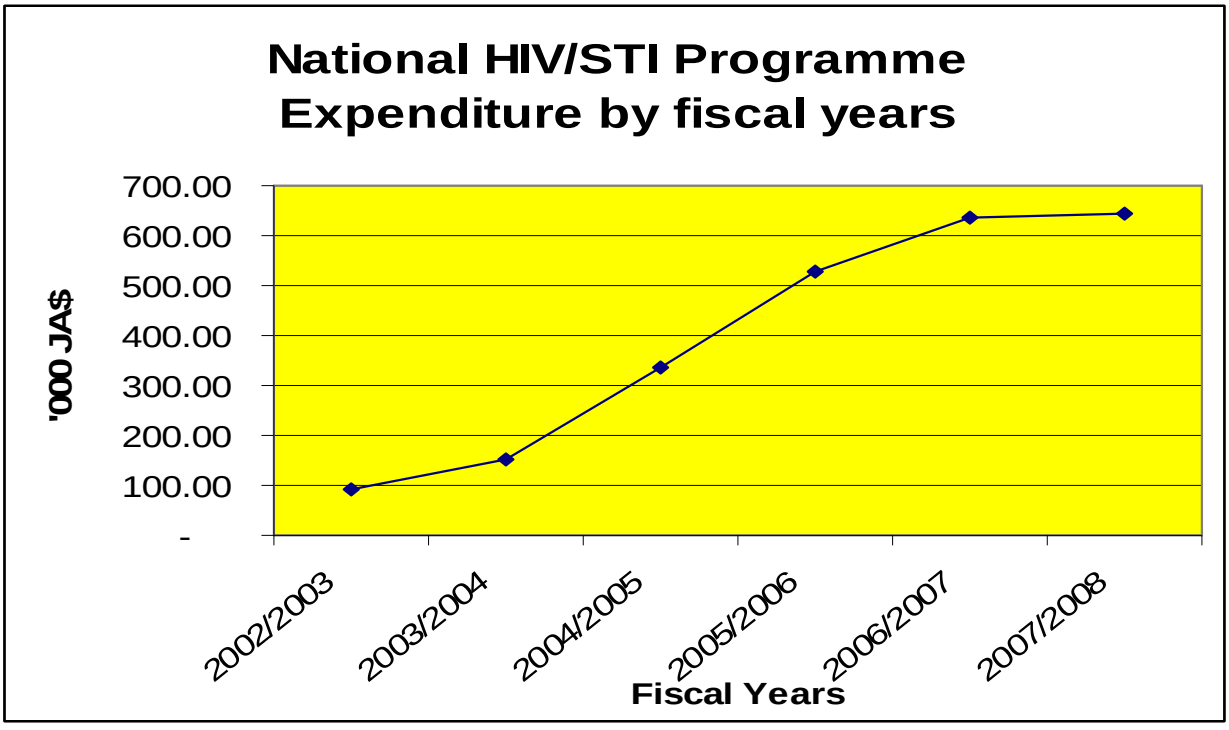
The Jamaica AIDS Support for Life (JASL) proposed JASL proposed research on the **Factors which may impact on Universal Access to Prevention, Care and Support in VCT services in sites across Jamaica**. This study will be client focused unlike previous VCT related studies that focused on the provider. An assessment of client perceptions of VCT was conducted in December using focus group discussions and surveys. The initiative was entitled "Translating JASL VCT research findings into action". The final report should be submitted in January 2008.

Funding and Support

FINANCIAL resources for the national HIV/AIDS response come from the Government of Jamaica, World Bank under a loan agreement with the Government and the Global Fund through a grant. Other contributions are provided by the United States Agency for International Development (USAID); the United Nations Children Fund (UNICEF) and the United National Joint Programme on AIDS (UNAIDS).

The National HIV/STI Programme had a budget of JA$797.205M during the calendar year 2007. This is 11% more than the estimated amount for 2006. The actual money expended in 2007 was JA$654.387M or 82.09% of the budget. This amount is 50% more than the amount spent in the 2006 calendar year. The shortfall in actual expenditure compared to the amount estimated, resulted mainly from delays in implementation of the Waste Management Plant in the South East Region and annual procurement of ARV drugs, which continued into the calendar year 2008.

Figure 4



Source: Financial Statements

The Programme's Administrative Management for the year 2007 increased five folds at the PCU level. This occurred because more than 95% of World Bank activities supported by the NHP were processed directly from the central office.

Less activity in this regard was carried out at the field level. This strategy was implemented to ensure that there is a timely mechanism in place to close out the World Bank Project.

A similar pattern was implemented in relation to the grant. Over 95% of the transactions were conducted at the central level. Some sub recipients were limited in administrative capability to receive and account of the grant resources. There was acceleration in terms of implementation of World Bank projects expected to close off within the year.

Work Activities

The **USAID** workplan was not approved in full as only US$$500,000 of the US$661,000 was approved for the period ending September 2007. The GoJ has however given a commitment to finance the shortfall. The project received a no cost extension to December 2007. The contract with the Consulting firm, IISPEC, to strengthen the technical capacity of NGO was terminated within the year as the expectations of the NHP were not being met.

Eleven (11) sub-recipients were active during the year for the **Global Fund** Project. There was a delay in finalizing some MOU Agreements and as such there was a gap for some implementers at the beginning of year 4 Global Fund. The full budgetary request for this project from the Ministry of Finance and the Public Service was approved. Negotiation is ongoing with the Global Fund to align their project year with that of the fiscal period of the Government of Jamaica.

Implementation of the Laboratory Information System and Waste Management Plant were the major items of expenditure for completion under the **World Bank Project**. The contracts were not being implemented rigidly in terms of time and the lessons learnt will guide the roll-out of phase 2 for both projects under the new World Bank loan being negotiated. Additional budgetary allocation has been sought for an increase by JA$51M, up from the JA$298.5M originally approved by the Ministry of Finance and the Public Service for the World Bank Project. This is to cover commitments under the Project.

A comparative summary for 2006 and 2007 per components and implementing entity is given in the below:

Table 24: Comparative Summary of Component Expenditure 2006/2007

	Calendar Year 2006		Calendar year 2007	
Components	Budget ('000 JA$)	Actual ('000 JA$)	Budget ('000 JA$)	Actual ('000 JA$)
Treatment, Care & Support	409.775	111.286	344.485	224.744
HIV Prevention	111.782	105.964	156.171	135.885
Capacity Building	42.344	71.336	103.008	93.264
Policy & Advocacy	34.665	22.215	40.666	24.448
Monitoring & Evaluation	7.517	3.466	7.631	7.864
Administration	78.346	58.135	69.925	75.795
HADDS	0.975	6.232	8.934	11.011
RHA	24.655	42.059	60.126	71.126
Line Ministries	7.569	9.847	6.259	10.250
Total	717.628	430.540	797.205	654.387

Source: Financial Statements

Even though the budget for HADDS and Regions increased by 816% and 144% respectively in 2007, these implementers and the Line Ministries over-expended the budgeted amounts in a bid to complete the ongoing activities by the end date of the World Bank Project in May 2008. The budget for capacity building increased by 143% as a result of network cable, furniture for NPHL, Computerisation of the Electronics Patients Records, minor civil works for treatment sites, buses procured for each region and the continued 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 for the Regional HIV/STI Programme response to the epidemic. This has positioned these entities to reap greater levels of success in the implementation of the 2nd World Bank Project which is to come on board next year.

Funds continued to be channelled to the following areas, 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, STI and OI Drugs, Reagents for PCR test, Viral Load test and CD4 Test, medical equipment and supplies, waste management plant, laboratory information system, 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.

Training
Medical doctors received sponsorship to attend the 4th IAS conference on HIV Pathogenesis, Treatment and Prevention held in July 2007. Three (3) PCU representatives participated in the Global Fund workshop held in April 2007 in Bogotá, Columbia aimed at addressing deficiencies in response to call for proposals with the Latin America and Caribbean Region. The World Bank facilitated local training in the Use of 'Client connection System' at their local office in June 2008, five persons from the PCU attended sessions.

Appraisals
Final Audited Financial Statements were received for the USAID Project for the end of the 2006 period. World Bank and Global Fund Projects received draft reports for periods ending in 2007.

The negotiation for the establishment of post to support the NHP is going well. It is anticipated that by April 2008 there will be a clear indication on the number and type of posts approved initially for absorption.

Mr. Daniel Ngowi, a consultant from Dar es Salaam who was supported by UNAIDS was contracted to Cost the National Strategic Plan 2007-2012. The Plan is estimated to cost US$201.2M to be fully implemented. The Plan is awaiting parliamentary approval.

Within the year the Programme responded to the Global Fund Round 7 call for proposal by submitting a proposal valuing US$44M to received grant funding to continue the support for fighting the HIV Epidemic. The proposal was approved in full.

The Programme underwent two (2) mission visits from the World Bank during the year, a new loan was conceptualise as a follow-on to the current with a value of US$10M. This is expected to be finalized within the next calendar year.

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