HIV and AIDS in Jamaica
National Strategic Plan
2007-2012

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC(s)	Antenatal clinic(s)
ART	Antiretroviral therapy
ARV	Antiretroviral
CCC	Caribbean Conference of Churches
CHC	Comprehensive Health Centre
SW	Commercial Sex Worker
BSS	Behavioural surveillance surveys
ERTU-CHART	Epidemiology Research and Training Unit of the Caribbean HIV/AIDS Regional Training Network
FBO	Faith Based Organization
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HFLE	Health and Family Life Education
HIV	Human Immunodeficiency Virus
JCC	Juvenile Correctional Centres
LIS	Laboratory Information System
M&E	Monitoring and Evaluation
MLGCDE	Ministry of Local Government, Community Development and the Environment
MNS	Ministry of National Security
MOEY	Ministry of Education & Youth
MSM	Men who have sex with men
MTCT	Mother-to-child transmission
NAC	National AIDS Committee
NHP	National HIV/STI Programme
NGO(s)	Non governmental organization(s)
NHF	National Health Fund
NSP	National Strategic Plan
OVC	Orphans and Other Vulnerable Children
PAA(s)	Parish AIDS Association(s)
PLWHA	People living with HIV and AIDS
PMTCT	Prevention of mother-to-child transmission
STI(s)	Sexually transmitted infection(s)
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary counselling and testing

PREFACE

It may take the next decade to witness the real outcomes of Jamaica's quest for universal access to prevention services, and treatment, care and support. This ambitious achievement depends on the expanded multisectoral framework that is required to reduce transmission of new HIV infection; to mitigate the impact of HIV/AIDS on the people of Jamaica; and to achieve a sustained, effective multisectoral infrastructure and commitment to support the national response. For this reason, Jamaica is relying on the commitment of every single partner and stakeholder to implement jointly the National Strategic Plan for the period 2007 to 2012. The partnership team must therefore embrace the priority areas of prevention; treatment and care; enabling environment and human rights; and empowerment and governance.

Partner agencies will together build interventions around four main objectives: (1) To improve access to prevention services, specifically to most-at-risk populations; (2) To achieve universal access to high quality comprehensive treatment care and support in an environment that is non discriminatory and support adherence; (3) To decrease stigma and discrimination towards people with HIV and AIDS and those affected; and (4) To achieve a sustained multisectoral response to the HIV/AIDS epidemic.

It is critical that the implementing partners of the multisectoral team are linked to the core building blocks of the national response – the national authority, the national monitoring and evaluation system and this national strategic plan. Indicators to measure outcomes and impact have been set, revised and approved to guide all partners and stakeholders involved in the implementation of the plan. In keeping with national commitment, the vision and the principles of the National HIV/AIDS Policy guide this plan.

Prime Minister of Jamaica
The Honourable Orett Bruce Golding

EXECUTIVE SUMMARY

By the year 2012, Jamaica expects to reduce significantly the spread of HIV and the impact of AIDS while improving the quality of life for those already living with and affected by HIV and AIDS. This requires universal access to prevention services, and treatment and care for people living with HIV and AIDS. In preparation for the next decade, the response over the next five years must build upon the growing multisectoral support, lesson learnt and best practices. Against this background, realistic target indicators have been set for the development and implementation of the 2007 to 2012 National Strategic Plan on HIV/AIDS. It is therefore essential that all stakeholders in the national development process be involved in the national response as HIV/AIDS is an all-embracing development problem that affects the fabric of economic planning and development. The Government of Jamaica began its national response to HIV/AIDS in 1986 with the start-up of a comprehensive National HIV/STI Programme (NHP). By 1988, a civil society-led partnership group, the National AIDS Committee (NAC) was established to broaden participation and advise Government.

Situation Analysis

This national strategic plan presents the HIV/AIDS situation in Jamaica. With its mean population of 2.6 million, and its size of 11,424 square kilometres, Jamaica is the third largest Caribbean island. About 1.5% of the adult population is estimated to be HIV infected, with almost two-thirds unaware of their status. There are at least six countries in the Caribbean region with HIV prevalence rates higher than Jamaica's.

Between 1982 and the end of December 2006, there were 11,739 persons reported with AIDS in Jamaica. AIDS and sexually transmitted infections (STI) together have hit hardest the young and productive age groups (15-49 years) and are the second leading cause of death for both male and female 15 to 24 years old. AIDS case rates indicate men leading but indicate a narrowing of the gap between male and female.

All 14 parishes are affected with the most urbanized parishes (Kingston & St. Andrew, St. James and St. Catherine) continuing to have the highest HIV and AIDS case rates.

Although heterosexual transmission is reported by 90% of persons with HIV, the sexual practice of 40% of reported male AIDS cases in Jamaica is classified as unknown. This is due primarily to two reasons: late reporting and stringent criteria whereby men are not classified as heterosexual unless 'same sex' activity has been explicitly excluded. Other populations most at risk of HIV infection are vulnerable populations such as commercial sex workers (SWs) and their clients, men who have sex with men (MSM), those with a history of a sexually transmitted infection (STI), and adolescents, particularly adolescent girls.

Overall, there was no significant change in HIV infection of pregnant women in 2006, compared to 2005. The implementation of the Prevention of Mother-To-Child (PMTCT) programme in 2004 resulted in the testing of at least 90% of pregnant women presenting

to antenatal clinics. About 75% of HIV infected pregnant women received antiretrovirals (ARVs) in 2006 leading to a significant decrease in vertical transmission of HIV.

By early 2007, just over 5,000 children under the age of 15 years were orphaned by HIV/AIDS. During 2006, there were 73 new AIDS cases reported for children under 10 years, compared to 78 in 2005. In the same year, the number of female youth between 15 and 24 years newly reported with AIDS, was three times higher than their male counterparts. Such findings may be linked to the high rate of forced sex, sexual intercourse with HIV-infected older men and transactional sex.

Myths continue to affect risk assessment and result in risk behaviours. While Jamaicans are able to identify HIV prevention options, they fail to reject major myths, according to a 2005 survey. Meanwhile, intolerance of male same sex relations impedes prevention interventions and contributes to denial of risk among men who have sex with men (MSM).

The situational analysis also refers to surveillance data and notes that the HIV epidemic in Jamaica is driven by behavioural, economic and sociocultural factors.

Vision, Goal, Guiding Principles

The objectives, strategies and interventions described in this five-year plan are formulated within the context of the vision, goals and guiding principles:

Vision

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

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

Goal Statement

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

Guiding Principles

- Political leadership and commitment
- Good governance, transparency and accountability

- Multisectoral approach and partnerships
- Participation of persons living with HIV and AIDS (PLWHA)
- Equity
- Promotion and protection of human rights
- The programme must be evidenced-based
- Participation of target populations in the design of the programme
- Ten principles from the International Labour Organization (ILO) on HIV/AIDS in the world of work – recognition of HIV/AIDS as a workplace issue, non-discrimination, gender equality, healthy work environment, social dialogue, non-screening for purposes of exclusion from employment or work, confidentiality, continuation of employment relationship, prevention, care and support.

Priority Areas

The plan covers the four priority areas of Prevention, Treatment and Care, Enabling Environment & Human Rights, and Empowerment & Government.

Prevention

This area examines and addresses how underlying factors influence risk-taking or appropriate behaviour, what strategies are effective in changing or sustaining behaviour and how best to replicate successful strategies. This section also examines reasons for a lack of behaviour change in some areas despite behaviour change communication (BCC) efforts. Key to prevention efforts is for individuals to have the self-efficacy to adopt and maintain appropriate behaviour and thereby exercise responsibility to protect themselves and others from HIV particularly during sexual contact. Among the key challenges to prevention efforts are insufficient change in high-risk behaviours, no major shifts in condom use for the past decade, persistent inaccurate perceptions about HIV and AIDS, and infrastructural obstacles that threaten the quality of and access to prevention services.

Treatment and Care

This requires development and implementation of an extensive system of care that includes screening and diagnostic services, voluntary counselling and testing, psychological and social support, provision of specialized clinical care and improved access to antiretroviral medications. The major challenges to providing adequate access to health care services include the high proportion of infected individuals that do not know their HIV status; do not access antiretroviral (ARV) drugs or access care at a later stage of disease progression or do not adhere to the medication. Other challenges to

access include continued stigma and discrimination that prevent many from getting tested, poor health behaviours, failure to disclose HIV status to partners, lengthy process to procure drugs and equipment and a shortage of health and social service providers.

Enabling Environment & Human Rights

An enabling environment is one in which all Jamaicans regardless of real or perceived HIV status can be facilitated by policies, programmes and supportive legislation to reduce their risk of infection or re-infection and to access needed treatment and care. This kind of environment protects fundamental human rights and empowers people to make healthy decisions. Barriers that limit the creation of and support for these efforts include stigma and discrimination, failure to protect privacy and confidentiality across service sectors and workplaces, widespread gender role and sexuality stereotypes, inadequate and inappropriate education, persistent poverty and some religious beliefs.

Empowerment & Governance

Commitment from high-level leaders including politicians and those of the business sector is needed to integrate HIV/AIDS prevention and control strategies into existing human and social development programmes, as well as to implement effectively, a monitoring and evaluation system that can be used across sectors. Challenges to empowerment and governance activities include a limited and fragmented multi-sectoral response to HIV/AIDS programming, a monitoring and evaluation system that has limited involvement of stakeholders outside of the health sector and sector ministries, an inflexible and rigid process of procuring goods and lack of funds for sustaining HIV/AIDS services.

Each of the priority areas include strategies, which are designed to promote appropriate attitudes and behaviour on seven, cross cutting issues at every social level, from the individual to society as a whole. These issues are: Stigma and Discrimination; Policy and Legislative Change; Behaviour Change; Service Quality and Access; Capacity Building; Communication and Coordination; and Monitoring, Evaluation and Research. Indicators have been developed to measure universal access and to evaluate achievements developed for each strategy.

Methodology

A wide cross section of stakeholders has contributed to the development of the 2007 to 2012 National Strategic Plan. The feedback was generated during consultations and workshops held with civil society, persons living with HIV and AIDS, representatives of marginalized groups such as men who have sex with men and commercial sex workers, service providers, community leaders and neighbours, programme managers, policymakers and providers of technical and financial assistance. These partners were charged with reviewing epidemiological data and existing initiatives to identify challenges and solutions to preventing and controlling HIV and AIDS. The results of these preliminary consultations were then presented to key national and regional

stakeholders during a strategic planning retreat, where these ideas were used to develop specific objectives and strategies for the National Strategic Plan.

I. INTRODUCTION

Jamaica has confronted the HIV epidemic proactively for nearly two decades steered by the government-led National HIV/STI Programme (NHP) from 1986 and its multisectoral partner, the National AIDS Committee (NAC) established in 1988. While the programme's mainstay has been prevention utilizing behaviour communication strategies, considerable attention and resources have been dedicated to treatment and care. For the next five years at least, Jamaica will scale up its efforts as it focuses on the four priority areas of Prevention, Treatment and Care, Enabling Environment and Human Rights, and Empowerment and Governance.

This Caribbean island of 11,424 square kilometres and approximately 2.6 million people has made major accomplishments in dealing with HIV/AIDS aggressively. Noted achievements are increased access to antiretroviral (ARV) treatment, the prevention of mother-to-child transmission (PMTCT) programme, the expansion of voluntary, counselling and testing (VCT) islandwide, and the successful implementation of behaviour change communication (BCC) interventions. Among successes is the syndromic management of sexually transmitted infections (STIs) leading to a significant decline in the incidence of some STIs such as syphilis and congenital syphilis. Steps toward a more effective monitoring and evaluation system also are guided by a clear understanding of data collection needs and the data collection and feedback progress made by the Monitoring and Evaluation Unit established in 2004. The national response has also been guided by previous medium-term strategic plans and the National HIV/AIDS Policy approved by Parliament in 2005. An integral feature of major strides in the national response is the collaboration from the expanded multisectoral team of partners and the attempt to promote HIV/AIDS as a developmental issue.

Approximately 66% to 76% of adults with non-regular sexual partners report condom use at last sex over the past 10 years. The programme has identified the need for research to determine why the remaining proportion - 24% men and 34% women - engage in unprotected sex with a non-regular partner.

Within the context of true multisectoral partnership, the Government of Jamaica continues its commitment in confronting the HIV epidemic with the new multisectoral plan for 2007-2012. This National Strategic Plan is Jamaica next five-year framework to achieve three main goals:

- To reduce the transmission of new HIV infections
- To mitigate the impact of HIV/AIDS on the people of Jamaica, and
- To achieve a sustained, effective multi-sectoral infrastructure and commitment to support the national response to HIV and AIDS

Universal access to prevention, treatment and care is therefore essential for the achievement of each of these goals. The successful implementation of this plan requires a sustained effort to build on the existing comprehensive; multisectoral set of priorities, leverage resources and confront the underlying behavioural, social and political factors that are driving the epidemic. The full participation of each sector of society is key to the government's response. The plan identifies programme priorities, objectives and strategies to achieve them and takes into account global, regional, national and local trends and best practices.

Of importance is the execution of the plan within a structure that is recognised as the main authority for responding to HIV/AIDS in Jamaica. The Government of Jamaica recognises the National HIV/STI Programme (NHP) with its multisectoral partner the National AIDS Committee (NAC) as the national authority. This national strategic plan will ensure that the three ones principle advocated by the Joint United Nations Programme on HIV/AIDS (UNAIDS) is recognised and integrated as an underlying theme. The three ones principle includes one national authority, one national strategic plan and one national monitoring and evaluation system. Successful execution of the 2007-2012 National Strategic Plan on HIV/AIDS requires full participation in implementation, monitoring and evaluation from all sectors, from civil society, private sector, high level leaders, young people, children, women, men, marginalized groups and persons living with and affected by HIV and AIDS.

II. PARTNERS IN THE NATIONAL RESPONSE

Each partner is an important member of the national response with specific rights and responsibilities. The integration of partners and stakeholders into the national HIV/AIDS response is a core strategy for achieving true multisectoral participation. Partners vary from government to the wider civil society, from individual to group, and from persons living with and affected by HIV and AIDS to service providers and policy makers. Influentials at every level are also important to the national response to build and maintain strong leadership.

Government through its parliamentarians and cadre of civil servants has a responsibility to ensure coherence and coordination of the national response. This includes the establishment of a comprehensive policy and legislative framework within an enabling environment of multisectoral participation. As the largest employer, government also has a responsibility to provide and increase access to prevention education, to treatment and care; and to set up structures and systems to reduce HIV-related discrimination.

Civil Society[1] must become an equal partner with government to implement various categories of the national response. It also has a watchdog role to ensure and to pressure government to fulfil its role and responsibilities. Civil society also needs to be involved in sustained advocacy for the protection of the rights of all Jamaicans and in particular the rights of the vulnerable and the marginalized.

Vulnerable groups such as people living with HIV and AIDS, adolescents and youth, street and working children, men who have sex with men, commercial sex workers and inmates are also important partners for interventions from the design phase to evaluation.

People Living with HIV (PLWH) have been actively involved in all areas of the national strategic planning process. They have specific roles to: (1) advocate and ensure that HIV/AIDS remains on the public agenda, and to (2) systematically identify and report acts of HIV-related discrimination. Stigma, discrimination and acts of hostility against people living with HIV are reportedly major factors that help to drive the epidemic underground. Additionally, persons who may be infected are unwilling to discover their status and so avoid being tested. (3) Another role for PLWH is to become a role model for 'Prevention in Positives'. While primary prevention remains focused on those who are HIV negative, people known to be living with HIV need to protect themselves from re-infection as they protect others from new infection. With the advent of antiretrovirals (ARVs), people are not only living longer, but are continuing to be sexually active. The "Prevention in Positives" message – Use a condom every time - needs to be sustained in prevention interventions among HIV positive persons because HIV transmission risk behaviour has been found to increase proportionately over time from diagnosis of HIV infection.

[1] Civil society may be defined as the classification of all entities including the private sector, which are not directly under Government's purview.

The National HIV/STI Programme (NHP) located within the Ministry of Health was mandated by the Government of Jamaica to coordinate and lead the implementation of the national HIV/AIDS response. Since the inception of the programme in 1986, its implementation arm has been expanded to involve the health sector's four Regional Health Authorities and five sector ministries – Labour and Social Security, National Security, Local Government & the Environment, Education and Youth, and Tourism Entertainment and Culture. The National HIV/STI Programme also provides technical and financial support for the National AIDS Committee (NAC), created in 1988 and strengthened since then to expand the multisectoral support. As the programme's capacity expanded so did its collaboration with funding agencies, other public sector organizations, and the rest of civil society. By the end of 2006, the cadre of implementing agencies involved in the national response included all government ministries, the tripartite team of government, employers and workers, the business sector and non-governmental organizations including faith-based entities. All have been supported through technical and financial inputs from NHP.

The National AIDS Committee (NAC) has been strengthened considerably to attract and sustain the participation of non-health and non-governmental entities in the national response. Members have been recruited and have volunteered to serve on one of the following tiers of the NAC:

- The Executive Committee
- Legal & Ethical Sub Committee
- Fund Raising Sub Committee
- Education Sub Committee
- Sub Committee of International Development Partners
- 13 Parish AIDS Association

The NAC is supported by a small Secretariat headed by an Executive Director.

The Finance and Planning Sector clearly recognises that the HIV/AIDS epidemic can undermine developmental goals. This sector has been involved in the national HIV/AIDS response. The Ministry of Finance and Planning has facilitated the National HIV/STI Programme by ensuring *inter alia* that grant and loan funds for the programme are given priority in the budget and warrant process. In addition, a representative of the National AIDS Committee sits on the National Planning Council (NPC) chaired by the Minister of Finance. The NPC has identified among its priority issues, the effective response to HIV/AIDS. The Planning Institute of Jamaica (PIOJ) has also facilitated planning and policy issues and supported public and other special consultations.

The Education Sector reaches every school-age child absorbed into the formal education system. It is therefore a critical partner in ensuring the adoption of risk

reduction behaviours and life skills. This sector has a crucial role in helping to dispel myths about HIV transmission and to establish zero tolerance for HIV/AIDS-related discrimination. The sector has been involved in the national response and has made some progress in institutionalising HIV/AIDS prevention within the sector. The Health and Family Life Education (HFLE) curriculum targeted to early childhood, primary and secondary levels for instance, has been revised to include sexuality and HIV/AIDS and piloted in teacher training colleges. Considerable progress has also been made in sensitising the sector to the National Policy for HIV/AIDS Management in Schools. A newly recruited cadre of health promotion officers who are expected to be absorbed into the ministry's permanent staff has facilitated promotion of and adherence to this policy. Additionally the sector has developed and reproduced educational materials to support the curriculum.

Despite these achievements however, the Education Sector has to be further supported to expand the response to the school-age population and their parents and guardians. This expansion should cover HIV/STI risk-reduction among the student population and the preparation of teachers, other school employees and parents to understand and support discussions and skills for both abstinence and condom-use. While the primary prevention option to the school population is delayed sex; condom-use skills need to be promoted in preparation for sexual activity and risk reduction behaviour. The sector is strategically positioned to reach and to impact the risk behaviours of a group of children and adolescents who are vulnerable to HIV and STIs. Also relevant in the school context is the establishment of a non-discriminatory environment. This requires structured and sustained interventions. In undertaking its unique role the Education Sector should address the following:

- Develop and implement a comprehensive response that engages the sector at all levels: i.e. early childhood, primary, secondary and tertiary.

- Increase the capacity in the sector to implement life skills-based Health and Family Life Education (HFLE) that seek to impact the behaviour formation and modification of the beneficiaries.

- Support the development of policies that will contribute to a supportive environment for the reduction of stigma and discrimination within the sector.

- Full ownership of the response resulting in budgetary allocation for required staff cadre to implement HFLE.

- Capacity building of resource personnel to implement HFLE and overcoming the cultural resistance that often plagues educators on the topic of sexuality.

- Monitoring and evaluation mechanisms

The Health Sector has been leading the response to HIV/AIDS in Jamaica through the National HIV/STI Programme (NHP) located in the Ministry of Health. However, HIV/AIDS is not fully integrated into the planning and operations of the health sector.

The priority agenda item of treatment and care is primarily managed and coordinated by and through the health sector. The expansion of the BCC strategy to achieve risk reduction began within the health sector through the regional health authorities (RHA). The process cannot be sustained without government's commitment to absorb selected posts and programmes. Government commitment is required for the full integration of HIV/AIDS into the health sector and other key sectors.

Other Key Public Sector Groups

The Labour Sector's role has gained increased significance through Jamaica's commitment to the guidelines and principles of the International Labour Organization (ILO) in relation to HIV/AIDS and the world of work. The national programme has supported the tripartite partnership in advocating and sustaining HIV/AIDS in workplace settings. This partnership has paved the way for Cabinet approval of the National HIV/AIDS Workplace Policy (2007) and preparations for piloting a Bill to amend the Occupational Health and Safety Act for the effective integration of HIV/AIDS into operational plans. The national HIV/AIDS response includes the commitment, advice and interventions of the tripartite team of government, employers and workers represented through the combined efforts of the Ministry of Labour and Social Security (MLSS), the Jamaica Employers Federation (JEF) and the Jamaica Confederation of Trade Unions (JCTU). The JEF and the JCTU have developed HIV/AIDS workplace policies and continue to coordinate interventions to guide their constituents. From 2001, this support was reinforced with the involvement of sector ministries each having an adaptation of the National HIV/AIDS Policy geared to their respective sectors. By 2004, the ILO established a project in Jamaica - ILO/USDOL Education Workplace Programme - that further strengthened the role of the tripartite team in workplace interventions. For the next five years, the Labour sector will need to expand its role in leading the response to the labour force. This involves special research and sportive legislation to mitigate the impact of HIV/AIDS on the formal workforce as well as interventions to reach the informal sector.

The Ministry of Labour and Social Security (MLSS) has provided increased visibility and awareness of workplace principles advocated by the International Labour Organisation (ILO). It has led the way in the development of a National HIV/AIDS Workplace Policy (2007) with support from the Jamaica Employers Federation (JEF) and the Jamaica Confederation of Trade Unions (JCTU). This ministry has also set the stage for HIV/AIDS workplace issues to be incorporated into the Occupational Health and Safety Act and thereby paving the way for all organisations to adopt HIV/AIDS workplace policies and implement programmes. The MLSS has also provided access to social welfare for People Living with HIV through its PATH Programme.

The **Ministry of Tourism** with support from the Jamaica Hotel and Tourism Association (JHTA) has promoted the Tourism HIV/AIDS workplace policy within the sector and increased the presence of condom outlets within the sector. Such outlets have been placed within staff environments and not in hotel rooms and other points accessible to guests. The Tourism ministry is also well positioned to become a partner with the National

HIV/STI Programme in reaching vulnerable populations within the sector. The tourism sector like others need to incorporate HIV/AIDS into mainstream plans, where the mitigation of the impact of HIV/AIDS will be recognized as relevant to development goals and objectives within the sector.

The **Ministry of National Security** is the access point to the incarcerated population. This ministry has already helped to provide non-traditional methods of dealing with risk reduction within prisons through cultural approaches and the involvement of inmates and correctional officers. As the estimated HIV prevalence within prisons is higher than the national HIV prevalence rate, the partnership with the Security ministry is essential in reaching the staff and inmates with effective and meaningful programmes.

Other public sector entities have partnered with the NHP to develop and implement HIV/AIDS workplace programmes annually through a Focal Point on HIV/AIDS, an HIV/AIDS workplace policy and implementation plan. This partnership needs to be expanded and owned by the respective entities.

The Business (Private) Sector needs to locate HIV/AIDS issues within its corporate and operational agenda and establish and sustain training and advocacy to help management and employees understand that such a step is vital to mitigate the impact of the epidemic on the business sector. This sector through the Jamaica Business Council on HIV/AIDS (JABCHA) has an integral role in relating HIV/AIDS workplace issues to costs and benefits in the management of profit and loss. HIV/AIDS is a factor that must be considered by every company in their planning and operations. The JABCHA should endeavour to support the tripartite approach to workplace policy development and implementation advocated by the ILO and supported by the NHP in its national policy.

The NGO Sector has a long history of involvement in the national HIV/AIDS response. This sector is part of the broader concept of civil society (that encompasses every arm of the society outside of the public sector). The non-governmental (NGO) sector has specifically conducted and coordinated prevention interventions which have reached several audiences including; adolescents, sex workers, men who have sex with men, persons living with HIV and AIDS, as well as adults in low income communities. The national programme has consistently supported the efforts of NGOs such as the Jamaica Red Cross, Jamaica AIDS Support for Life, ASHE performing ensemble, Children First and Hope Worldwide. Numerous challenges have been encountered in collaborating with non-governmental organizations (NGOs) and in addressing some of these challenges the sector will have to be further supported in regards to:

- Capacity Building to implement interventions that focus on engaging their audience in risk reduction conversation and build self efficacy
- Sustainability
- Monitoring and evaluation

Churches and Other FBOs are important players in the response. Several groups are already involved with some developing church policies dealing with HIV/AIDS and others offering hospice and care services. Many individuals within churches and FBOs need support to assess their risk of HIV and dispel misconceptions, which increase their risk of infection or encourage unacceptable attitudes and behaviour to persons living with HIV and AIDS. To facilitate this effort, collaboration with the NHP would help to build the capacity of leaders and change agents to deliver accurate messages and perform appropriate counselling and education.

Social Agencies: Social networks are important in providing voice and agency to individuals susceptible to HIV, and in organizing the solidarity mechanisms needed for supporting households and the community response. They are particularly important in terms of those forms of support that enable effective and equitable prevention and caring responses to HIV and AIDS. All social agencies therefore need to incorporate HIV/AIDS into their structures and systems dealing social support for treatment and care.

Media: The media have engaged in advocacy and have provided visibility for HIV/AIDS issues. Several media entities have worked more directly with the national programme in the production of material while others have produced HIV/AIDS-related programmes on their own initiative. An alliance was formed with media managers for rebates in the cost of placement of campaign messages. Media entities need to be part of the workplace and business sector response in institutionalising HIV/AIDS training and sensitisation for staff, management and their target populations.

Champions For Change: Leaders at every level can offer assistance as HIV/AIDS change agents and advocates to promote risk reduction behaviour and/or lobby for policy and law reform to encourage an enabling environment for the protection of the rights of all Jamaicans in particular people living with and affected by HIV and AIDS. These champions are required to ensure that their constituents have access to prevention education and skills and treatment care and support services through a sustained programme.

Families have a responsibility to offer the first line of support to people living with HIV and assist in preventing acts of discrimination towards them. Families also need to be informed to protect their members especially minors from infection. Families of PLWH are among caregivers trained to provide home-based care. The response from many families has been hindered by misconceptions about HIV and AIDS which in some cases result in acts of discrimination from within the home. For this reason PLWH would rather disclose their status to friends and other relatives. There is a need for expanded training and sensitisation efforts to families of PLWH.

Individuals need to practise safer sex, know their status and treat each human being with dignity and respect. In particular, those particularly vulnerable to infection or re-infection

must practise safer sex, know their status, become part of a support group, lobby for the protection of rights, and respect, and report acts of stigma and discrimination.

Regional Partners

The NHP liaises with the several regional institutions among them the Pan Caribbean Partnership Against HIV/AIDS, the Caribbean Regional Strategic Framework, the University of the West Indies, the Caribbean Broadcasting Media Partnership on HIV/AIDS, the Caribbean Coalition of National Programme Coordinators, and the Caribbean Network of Persons Living with HIV and AIDS. This alliance has increased the visibility of the Jamaican programme in the region which has resulted in Jamaica offering guidance and technical assistance in interventions leading to risk reduction strategies and programmes, national HIV/AIDS policy development, greater involvement of people living with HIV in the national response, and the identification of champions for change among leading influentials. Jamaica needs to plan more directly for the documentation and the promotion of its best practices for greater collaboration with its regional partners.

Resident International Partners

The UN Theme Group on HIV/AIDS in Jamaica assists in the identification of strategies for the national response. The Theme Group plays a key role in mobilizing funds and in designing and piloting projects. Through joint programming, the UN Theme Group is able to identify potential overlaps in assistance and resource gaps and this further strengthens the capacity of national institutions and streamline coordination. As the multisectoral support expands, the Theme Group must also broaden its capacity to build collaboration and reduce duplication.

Jamaica's response to HIV/AIDS depends to a large extent on grants and loans from international development agencies. Key partners in providing financial resources through grant and loans are the Global Fund to Fight AIDS, Tuberculosis and Malaria, the International Bank for Reconstruction and Development (IBRD), the United States Agency (USAID) for International Development and the United Nations Children's Fund (UNICEF). Other assistance has come from the Pan American Health Organization (PAHO), the Britain's Department for International Development (DFID), the Canadian International Development Agency (CIDA) and the International Labour Organisation (ILO). These organisations are primarily involved in collaborative efforts to: promote positive behaviour change; provide funding, and to building capacity and advocacy.

Other Partners

Service Providers have a responsibility to treat every client with respect and compassion during prevention and treatment efforts regardless of age, income, gender, occupation or sexual orientation.

Community Leaders and Neighbours need to operate within support systems for people living with HIV and AIDS so they may live free of stigma and discrimination.

Programme Managers and Policy Makers have a responsibility to develop efficient, effective systems of care that reach across sectors and provide quality services; and that creates and sustains enabling environs to protect basic human rights of all Jamaicans.

III. METHODOLOGY

The National HIV/STI Programme adopted a consultative and evidence-based approach in developing the National Strategic Plan (2007- 2012). The process brought together a broad array of partners to review the epidemiological data, evaluate the existing initiatives and to examine and discuss potential challenges and solutions. The methodology for the strategic planning process was developed by the National HIV/STI Programme in consultation with regional health authorities; sector ministries, non-governmental organizations (NGOs), the United Nations Theme Group on HIV and AIDS and representatives from the community of people living with HIV.
The following considerations were integral to the development of the methodology:

- **The broad participation of civil society is essential.** This broad participation includes young people, people living with HIV (PLWH), men having sex with men (MSM), commercialsex workers (SWs), faith-based organizations (FBOs), non-governmental organizations (NGOs), private-sector representatives and government decision makers. The inclusion of all of these groups is essential in the definition of the National Strategic Plan and to foster ownership during its subsequent implementation.

- **Multi-sectoral participation in the development of the National Strategic Plan must be guided by a shared vision and set of priorities.** Each stakeholder should contribute to the national response based on their specific population(s) and their own strengths. Each must recognize and take ownership of their unique role in achieving universal access to treatment and prevention. Additionally, it is important that areas for coordination among stakeholders are identified and the mechanisms to achieve this coordination are developed.

- **The National Strategic Plan should be both comprehensive and specific.** The plan identifies stakeholders' roles and responsibilities within agreed priority areas. Crosscutting themes such as empowerment, policy considerations and monitoring and evaluation are being addressed within each priority area.

- **Factors driving the epidemic must be examined.** In order for the National Strategic Plan to identify effective strategies and activities, there must be a concerted effort to examine the factors that drive the epidemic for example gender roles and inequities, sexual patterns and social vulnerability. Consultation with experts in these fields is essential.

- **The UNAIDS "Three Ones" must be adapted and harmonized for the Jamaican context.** The process of developing the strategic plan will advance the discourse on the UNAIDS conceptual guidance of one national framework, one national authority and one monitoring and evaluation system. Both sector and civil society representatives must come together to help decide on the best ways to further the governance of the national response.

To meet these considerations, the process of developing the plan engaged a broad range of public and private partners through consultations with youth, regional health workers, civil society and the Jamaica Business Council on HIV/AIDS (JABCHA). Specialized consultations were also held with experts and lead decision makers on 1) gender roles and sexual patterns and 2) policy and social vulnerability. The results of these preliminary consultations were then presented to key stakeholders during a strategic planning retreat. These stakeholders who represented public and private entities at national and regional levels then participated in the development of specific objectives and strategies for the National Strategic Plan.

IV. SITUATION ANALYSIS

This section of the report provides the epidemiological profile of HIV/AIDS in Jamaica. It also provides a synopsis of the successes of current efforts and the challenges that lie ahead. This analysis provides the roadmap for the objectives and strategies articulated in the National Strategic Plan.

A. Epidemiological Profile of HIV in Jamaica

Jamaica is the third largest island in the Caribbean and has a mean population of 2.6 million. The HIV epidemic in Jamaica has features of both a generalized and concentrated epidemic. It is estimated that 1.5% of the adult population is HIV infected but higher HIV prevalence has been recorded in vulnerable groups such as SW (9%); MSM (20 to 30%), persons with STIs (4.6%), crack/cocaine users (5%), and prison inmates (3.5% to 12%). Almost two thirds of HIV infected persons are unaware of their status.

At the end of 2006, the cumulative number of persons reported with AIDS in Jamaica was 11,739. Within the same time frame, the cumulative number of AIDS deaths was 6,673 (*Appendix B*). AIDS and sexually transmitted infections (STI) are the second leading cause of death for both men and women in the 15-24 year old age group. Approximately 65% of all reported AIDS cases in Jamaica are in the 20-44 year old age group, and 90% of all reported AIDS cases are individuals between 20 and 60 years old. AIDS case rates among men continue to exceed AIDS case rates among women although recent data suggest that the gender difference may be narrowing.

All 14 parishes are affected by the HIV epidemic but the most urbanized parishes have the highest cumulative number of AIDS cases (St. James – 992 AIDS cases per 100,000 persons and Kingston & St. Andrew – 697 cases per 100,000 persons). In 2006, the parishes of St. James, St. Catherine and Kingston & St. Andrew reported the highest number of cases of HIV infection in Jamaica. However, parishes such as Portland, Westmoreland, Manchester and Clarendon showed a significant increase in 2004 compared to the previous year. In 2006, the cumulative reported AIDS cases (1982-2006) ranged from 157 per 100,000 people in Manchester to 992 per 100,000 population in St. James.

Table 1. Epidemiological Profile: HIV/AIDS Indicators

Indicators	Jamaica
HIV prevalence rate, aged 15-49	1.5% (2005)
HIV prevalence rate among SW	9.0% (2005)
HIV prevalence rate among MSM	20 to 30% (2006 estimate)
HIV prevalence rate among STI clinic attendees	3.8% (2004) 4.6% (2005)
Reported AIDS deaths	665 (2004) 514 (2005)

Risk Factors and Most Vulnerable Groups. Although heterosexual transmission is the main route of transmission of HIV (reported by 90% of persons with HIV), the sexual practice of 40% of reported male AIDS cases in Jamaica is unknown and many of these persons may be men who have sex with men (MSM). Among reported male AIDS cases on whom data about sexual practices are available (60% of cases), homosexual or bisexual activity is reported by 14% of men. For example, in 2006, about 25% of people living with HIV (PLWH) reported 'sex with prostitutes' as one of their risk factors and almost one out of two persons living with AIDS had a history of STI as a risk factor. Among STI patients, HIV prevalence has increased from 3% in patients tested in 1990 to 4.6% in 2005.

Table 2: AIDS Cases in Jamaica by Risk Category (1982 – 2006 cumulative)

RISK	NO. OF PERSONS (%)
Sex with sex worker	2104 (24.5)
Crack, Cocaine Use	715(8.3)
STI History	3966 (46.1)
IV Drug Use	92 (1.1)
Multiple Sexual Partners/Contacts	~ 80%
No known high risk behaviour	~ 20%
Total	8597 reported

Behavioural surveillance of the general population and vulnerable groups confirm some of the risk factors in Table 2. The most recent population survey (KABP 2004) showed a persistence of risky behaviours such as multiple partners (50% men), participation in transactional sex (20% of men and women), and failure to use condoms with non-regular

partners (30% of men, 40% of women). These behaviours may be driven by myths concerning HIV and lack of personalization of risk as only 36% of young men and 40% of young women were able to correctly identify ways of preventing HIV and reject major misconceptions about HIV. Similarly, a 2005 survey of sex workers indicated that 32% of HIV negative SW and 18% of HIV positive SW were able to correctly identify ways to prevent HIV infection. Risky behaviour is also evident among adolescents as the median age of first sex declined to 15.7 (males) and 17.2 (females) in 2004. A 2005 survey of in-school adolescents (10 to 15 years old) reported that 12% of those surveyed admitted to being sexually active, 56% had 2 or more partners, and 48% reported no condom use at last sex.

Below is a description of the specific features of the HIV/AIDS epidemic in Jamaica in some vulnerable populations.

Pregnant Women: In 2005, for every 1,000 pregnant women in Jamaica, 15 were infected with HIV (representing a prevalence of 1.5%). Higher HIV infection rates were observed from the parishes of Westmoreland (2.08%), St. James (1.98%) and Manchester (1.86%). Overall, there was no significant change in HIV infection of pregnant women in 2005, compared to 2004. In 2004, a PMTCT programme was implemented at all major hospitals and health centres resulting in the testing of at least 90% of pregnant women presenting to antenatal clinics. As a result, at least 75% of HIV infected pregnant women received ARVs to prevent mother-to-child transmission (MTCT) in 2006 leading to a significant decrease in vertical transmission of HIV.

Children: By early 2007, an estimated 5,125 children under the age of 15 years were orphaned by HIV. In 2006, a total of 73 new paediatric AIDS cases (children < 10 years old) were reported compared to 78 paediatric AIDS cases in 2005. The lack of reduction in pediatric AIDS cases is attributed to active case finding by health care workers (HCW) sensitised to recognition of the HIV infected child. In 2003, AIDS was the second leading cause of death for children in the age group 1-4 years. However, the introduction of ARV treatment has resulted in a significant reduction in deaths due to pediatric AIDS (34 deaths in 2004 compared to 13 deaths in 2006).

Young People: Population estimates for 2006 indicate that 290,000 adolescents reside in Jamaica. In 2006, the number of newly reported AIDS cases in young girls in the 15-24 year old age group was two times higher than that of boys of the same age group. In 2005, adolescent females in the 10-14 year old age group had twice the risk of HIV infection than boys of the same age group. In the same year, adolescent females in the 10 to 19 year old age group had three-times-higher risk of infection than boys of the same age group. These findings may be related to the high rate of forced sex, sexual intercourse with HIV-infected older men and transactional sex.

A 2005 survey of in-school children (10 to 15 years old) revealed that 12% of surveyed adolescents were sexually active and of these, 56% had two or more partners (including 18% of respondents who had 6 or more partners) and 48% of male students reported no condom use at last sex. Although most adolescents agreed to their first sexual encounter,

9% of boys and 24% of girls reported that they were forced to have sex on their first sexual encounter. Similarly, the most recent reproductive health survey found that one in every five girls, 15-19 years, is forced to have sex.

SW: A 2005 survey of Sex Workers (SW) in the most urbanized areas of Jamaica revealed that knowledge about ways to prevent HIV/AIDS transmission was high but rejection of myths was low among SW, as in the general population. Ninety-seven percent of SW reported having easy access to condoms (accessible within 5 minutes) and condom use with clients (≥ 90%) was significantly higher than condom use with non-paying partners (52%). HIV prevalence was found to be 9% in this population although a previous survey suggests that this may be higher. For example, 25% of PLWH reported 'sex with prostitutes' as one of their risk factors and in 1994-1995, twenty-five per cent of sex workers tested in Montego Bay were HIV positive.[2]

Inmates: An estimated 5,000 persons were incarcerated in Jamaica 2005. All warders and inmates are part of an ongoing education and health programme that uses creative and cultural approaches to HIV/AIDS knowledge and skills building. Sodomy is illegal in Jamaica so prison authorities are not in a position to consider condom access to inmates though they acknowledge high HIV risks among the inmate population. This is reinforced by the findings of a 1997 survey of 1,000 male inmates that showed an infection prevalence of 6.7%. A recent estimate in one institution found the HIV prevalence among inmates to be 3.5%.

MSM: From 1994-1996, the HIV prevalence in major urban areas for men who have sex with men (MSM) ranged from 30% to 67% (UNAIDS 2004). Currently, it is estimated that the MSM population in Jamaica varies from 9,000 to 27,000 and 20 to 30% of MSM are HIV infected. Surveillance data among this population is sparse because many of those who are HIV infected do not disclose their sexual practices. This is reflected in HIV surveillance data in which the sexual practices of 40% of reported male AIDS cases is unknown. Although this is partly attributed to late reporting, some of these may be men who have sex with men.

History of STIs: In 2005, more than 40,000 persons were seen at public STI clinics and sentinel surveillance of this population shows that HIV prevalence has increased from 3% in 1990 to 4.6% in 2005. Almost one out of two reported AIDS cases in 2005 had a history of STI as a risk factor.

Factors Driving the Epidemic

Surveillance data indicate that the HIV epidemic in Jamaica is driven by some main factors:

Behavioural: Despite a rapidly expanding prevention programme, risky behaviours such as multiple sex partners, early initiation of sex, involvement in transactional sex and non-use of condoms have fuelled the HIV epidemic over the last decade. Persons who deny or are unable to calculate their personal risk often times get caught in the trap of unprotected sex. This fuels the inconsistency between HIV prevention knowledge and behaviour.

Economic: The HIV/AIDS situation is affected by Jamaica's slow economic growth, high levels of unemployment; persistent poverty; the burgeoning informal sector in relation to the illegal drug trade and commercial sex; tourism and population movements.

Sociocultural: Stigma and discrimination drives those most-at-risk underground. Gender dimensions influence prevention options. Men are often the sexual decision makers, thus condom use negotiations are difficult for women. Widespread homophobia affects condom distribution in prisons and hinders interventions among MSM.

V. VISION

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

This vision statement guides the national response, the National Strategic Plan and the National HIV/AIDS Policy, which was approved by the Jamaican Cabinet and Parliament in 2004 and 2005 respectively.

VI. GOAL STATEMENT

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

VII. GUIDING PRINCIPLES AND VALUES

The Guiding Principles of the National Strategic Plan 2007 – 2011 and the National HIV/AIDS Policy (2005) are:

Political Leadership and Commitment

Strong political leadership and solid commitment at all levels is essential for a sustained and effective response to HIV/AIDS.

Good Governance, Transparency and Accountability

An effective national response to the epidemic requires leadership to mobilize and manage human, financial and organizational resources in an effective, transparent and accountable manner.

Multisectoral Approach and Partnerships

The active involvement of all sectors of society is necessary to ensure an effective response, including effective partnerships, consultations and coordination with all stakeholders in the design, implementation, monitoring and evaluation of the national response to HIV/AIDS.

Participation of PLWH and Other Vulnerable Groups

The meaningful involvement of people living with HIV and other most vulnerable groups in the design, implementation, monitoring and evaluation of the national response to HIV/AIDS is vital to optimise stated outcomes.

Equity

This principle means that all responses to HIV/AIDS should ensure that no person shall be denied access to prevention knowledge, skills and services or treatment, care and support services on the basis of their real or perceived HIV status, sexual orientation, gender, age, disability, religious or other beliefs, socio-economic status, geographic location, level of literacy, capacity to understand the nature of HIV/AIDS and how it is prevented and treated or vulnerability to exposure. This includes orphans, wards of the state, MSM, SWs, street and working children, persons living with disabilities, and prisoners.

Promotion and Protection of Human Rights

An important aspect of the response to the epidemic requires that the rights to equality before the law and freedom from discrimination are respected, protected and fulfilled. Discriminatory practices (including unequal gender relations) create and sustain conditions leading to vulnerability to HIV infection. These practices also have an impact on treatment, care and support as well as access to prevention services. All interventions should be guided by promotion, protection and respect for human rights including gender sensitivity.

Evidence-based interventions

HIV prevention actions must always be based on evidence including what is known and proven to be effective and to make efforts to obtain evidence even in cases where it doesn't exist.

Participation of target population in design of programmes

Persons targeted for HIV prevention programmes including children, young people, women, men, men who have sex with men (MSM), Sex Workers (SW), inmates and others must be included in the design and implementation of these programmes to ensure success.

Ten ILO Principles on HIV/AIDS and the World of Work

Ten principles from the International Labour Organization (ILO) on HIV/AIDS in the world of work – recognition of HIV/AIDS as a workplace issue, non-discrimination, gender equality, healthy work environment, social dialogue, non-screening for purposes

of exclusion from employment or work, confidentiality, continuation of employment relationship, prevention, care and support.

The Convention on the Rights of the Child (CRC)

Jamaica ratified the United Nations Convention on the rights of the Child in 1991 and by doing so has committed the nation to respect, protect and fulfil children's rights. The CRC defines a child as a person aged 0 – 18 years with evolving needs. The foundation principles of the CRC are:

- Non-discrimination;
- The best interests of the child;
- The right to life, survival and development;
- The respect for views of the child.

VIII. ACHIEVING UNIVERSAL ACCESS

Universal access refers to increased uptake, access and sustained use of prevention services and treatment and care for people living with HIV. It emphasizes the urgency for action, in an equitable manner, in order to halt and reverse the HIV epidemic. Universal access is required for achieving the overarching goal of the Jamaica national response to HIV/AIDS that is, to reduce significantly the spread of HIV and to improve the quality of life for those living with and/or affected by HIV and AIDS. This important goal stems from a number of high-level international commitments, including the United Nations General Assembly resolution at the 2005 World Summit: "facilitating inclusive, country-driven processes, including consultations with relevant stakeholders, including non-governmental organization, civil society and the private sector, within existing national AIDS strategies, for scaling up HIV prevention, treatment, care and support with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all those who need it."

Several important steps are critical to Jamaica's ability to achieve universal access:

- Build upon its existing processes

- Establish ambitious, yet realistic, target indicators
- Develop and implement a multi-sectoral strategic plan to achieve these targets.

The National Strategic Plan 2007-2012 and the process leading to it followed these steps and addresses critical issues that will determine attainment of its goals. The NSP embraces strategies that:

- Decrease stigma and discrimination, resulting in increased acceptability of services and increase uptake.
- Strengthen the multisectoral response and improve the capacity of all stakeholders, resulting in increased quantity and quality of services, (increased availability and accessibility).
- Are evidence-based and comply with local, regional and international guidelines to inform the national response. This coupled with a strengthened M&E system will pave the way for an efficient and sustainable response to HIV.

The National HIV/STI Programme and its partners will monitor attainment of universal access by tracking key indicators. These indicators are specific, time-sensitive and practical (*See Figure 1*).

The process of defining universal access using the Target Indicators, followed by the use of consultations to critically assess existing efforts enabled stakeholders to develop priorities, objectives and strategies that build upon best-practices. The process also provided the opportunity to think creatively about new ways to overcome contextual and programmatic barriers. Through this process of reflection and analysis Jamaica developed

a conceptual model to articulate the multi-pronged, multi-sector effort that will be required to achieve Universal Access (*Figure 1*).

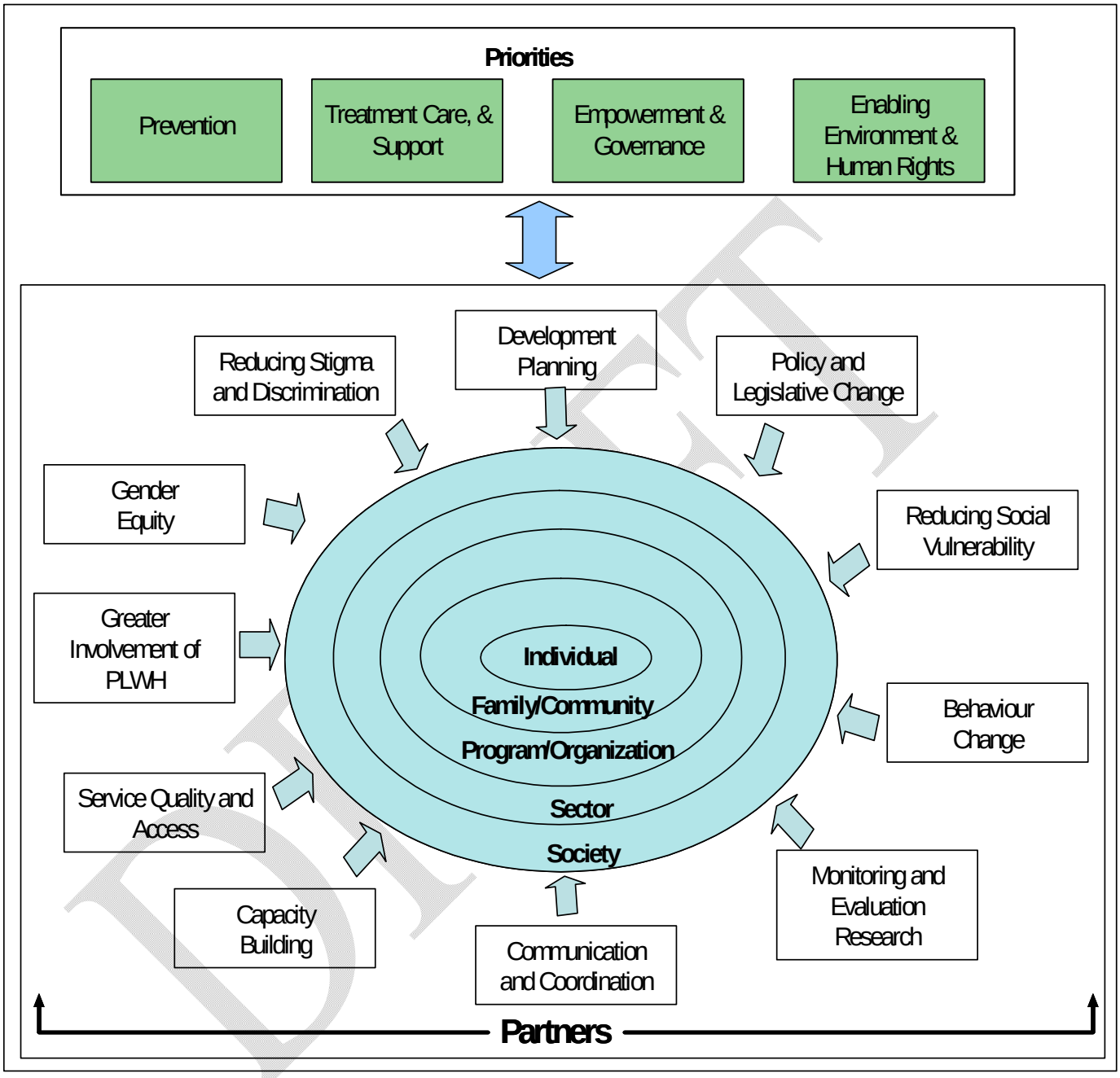
Figure 1. Target Indicators for Universal Access

1. Increase the median age of first sex by 0.5 years by 2012.
2. Increase the percentage of youth (15-24 years of age) or other "at risk" groups (MSM, SW) who correctly identify ways of preventing sexual transmission of HIV – including delaying sexual debut, reducing partners and use of condoms – and reject major misconceptions (male/female) from 36.2% of men and 40% women in 2004 to 65% in 2012.
3. Increase the percentage of young men and women 15-24 years of age reporting condom use the last time they had sex with non-regular partner from 74% men and 65.9% women in 2004, to 85% men and 75% women in 2012.
4. Increase the percentage of "at risk" groups (MSM, SW, adolescents) reporting condom use at last sex.
5. Increase number of Behaviour Change Communication/TCIs with most at risk sub-populations (MSM, SW, adolescents).
6. Increase the percentage of most-at-risk populations (MSM, SWs) and youth who received HIV testing in the last 12 months and who know the results (e.g. SW testing increased from 43% in 2005 to 50% in 2012).
7. Increase the percentage of women, men and children with advanced HIV infection who are receiving antiretroviral combination therapy from 40% to at least 80% by 2012.
8. Increase the percentage of adults and children on ART who are still alive 12 months after initiation of antiretroviral therapy.
9. Increase the percentage of HIV positive pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT from 47% in 2004 to 90% in 2012.
10. Maintain the ratio of current school attendance among orphans to that among non-orphans aged 10-14 at ≥ 0.9 (2012).
11. Implementation of the "three ones" principle: 1 national strategic plan, 1 national coordinating authority and 1 M&E system.

The complete M&E plan details 30 core indicators, which include the indicators of universal access. This M&E framework is available on the website of the NHP (**www.jamaica_nap.org**) and is summarized in Annex B according to the 4 priority areas and activities of this strategic plan.

(Targets stated reflect milestones towards universal access.)

Figure 2. Conceptual Model of the National HIV Strategic Plan



IX. PRIORITY AREAS

The four priority components are strategic areas that build upon the prior National Strategic Plan (2002-2006) yet have been revised to reflect the current status and issues. The priority areas include:

Prevention: A comprehensive programme of prevention services and strategies, which achieves full coverage and empowerment of all sexually active persons, including young people is essential to control of the HIV epidemic. In addition, there are significant portions of our population who are more vulnerable to becoming infected because of lack of education, poverty and gender inequities. There are populations that are especially vulnerable due to their sexuality or lifestyle choices such as MSM, SWs and those who engage in transactional sex, and inmates. Jamaica has shifted its focus from improving knowledge to examining how underlying factors influence behaviour, analysing which strategies are effective in changing behaviour, and looking at how best to replicate the successful strategies. The key to prevention efforts is for individuals to have the right to control their sexuality and exercise the responsibility to protect themselves and others from infection.

Treatment and Care: Jamaica increased public access to ARV treatment with the support of the Global Fund to Fight AIDS, Tuberculosis and Malaria in September 2004. In addition, Global Fund resources enabled the purchase of diagnostic and monitoring equipment (CD4, viral load etc.) and support to improve adherence to treatment. There has been rapid development and implementation of an extensive system of care, which includes screening and diagnostic services, counselling, psychological and social support, provision of specialized clinical care and improved access to antiretroviral medications. The next steps must be to improve the quality of care, overcome barriers to using the care and develop a streamlined system of coordination with the organizations best suited to provide the social support services. As importantly, the treatment programme is intricately linked to other health services, and a strong health sector is vital to achieving sustained and quality treatment, care and support for individuals with HIV and AIDS.

Enabling Environment and Human Rights: Jamaica has made much headway on developing HIV/AIDS related policies. Some of the most noteworthy include the National HIV/AIDS Policy, National Plan of Action for Orphans and Other Children made Vulnerable by HIV/AIDS in Jamaica 2003-2006, National Policy for HIV/AIDS Management in Schools, and the National Workplace Policy on HIV/AIDS. An important next step is to amend existing legislation or pass new laws to support the national HIV/AIDS response. Among such law reform tasks is to develop and pass an anti-discrimination law. Such laws must be enforced, and leaders at all levels have a role in ensuring compliance to them. Supportive legislation is needed to help protect the rights of all Jamaicans including the vulnerable and marginalized as action is taken to reduce discriminatory practices related to HIV/AIDS. Also important is amendment to the Public Health Act with HIV/AIDS specific regulations and the repeal of outdated legislation such as the Venereal Diseases Act, the Quarantine Act and the Leprosy Act. The

development of community-level advocacy, with the full participation of people living with HIV (PLWH) as well as the establishment of mechanisms for reporting discrimination and acting upon these reports, is also a critical next step.

Empowerment and Governance: The underlying issues of social vulnerability, poverty and gender inequities must be addressed to overcome barriers to HIV prevention, treatment, care and support. While much headway has been made in each of the sectors in the development of policies and programmes there needs to be a renewed commitment at the highest levels to implement HIV/AIDS strategies. Existing human and social development programmes should include HIV and AIDS efforts. There must also be a monitoring and evaluation system that can be used across sectors. Efficient procurement systems are required. Finally, the ways in which the response is managed across the sectors must be examined, with a focus on how to sustain HIV/AIDS efforts once international funding ends.

1. Prevention

Jamaica recognizes that prevention efforts must accomplish two important goals. First, prevention efforts must reach all Jamaicans. Second, such efforts must address the underlying social vulnerability, poverty and gender inequities that have an impact on behaviour. The Behaviour Change Communication (BCC) strategy is one of the National HIV/STI Programme's chief prevention tools. The BCC strategy provides the framework for the design, implementation, monitoring and evaluation of interventions conducted by the national programme and its partners. BCC activities are broad and varied, but the main focus is on risk reduction counselling and education while building self-efficacy to adopt or sustain appropriate attitudes and behaviour.

The prevention component of the national programme has evolved since its first campaigns of the late 1980s. The early emphasis of these campaigns that extended to the early and mid 1990's was on increasing awareness and knowledge and to a lesser extent behaviour change. The national Knowledge Attitude Practice and Behaviour (KAPB) surveys conducted from 1988-1994 pointed to significant increases in knowledge as much as 97% but a lagging in behaviour change approximately 47%. These results prompted the introduction and the intensification of strategies that would encourage behaviour change. Consequently there has been a mix of strategies that have been directed at the general population as well as clearly identified sub populations that practice behaviours that increase their risk of HIV infection.

The strategies have ranged from targeted interventions within geographical high transmission locations as well as targeted to specific audiences, to the use of cultural vehicles, various print and electronic media materials and mass media campaigns. The interventions have extended to the building of alliances and several collaborative efforts with the non-governmental organizations (NGOs) including faith-based (FBOs), and government organizations. During the collaboration with these organizations, the technical capacity of the agencies has been improved to deliver more effective behaviour change interventions. The emphasis of behaviour change continued within the programme. Several interventions based on existing theoretical models were implemented.

The implementation arm was expanded to include five sector ministries with increased focus on workplace policy development and implementation. This approach assisted the establishment of enabling environments within government worksites for encouraging safer sexual behaviours.

In the meantime, increased collaboration with NGOs and non-health government sectors resulted in the expansion of interventions to targeted communities and workplaces. It also built the technical capacity of sector and community groups to conduct interventions based on behaviour change communication strategies.

The health sector's capacity to deal with prevention was improved with the expansion of a cadre of outreach behaviour change community peer educators and introduction of

(PLACE) – Priorities for Local AIDS Control Efforts. PLACE provided another research and intervention tool to identify sites where people meet new sexual partners, confirm them and conduct randomised control trials.

Achievements

Some of the key BCC recent achievements:

- Establishment of an alliance with media managers facilitated substantial discounts in the placement costs for mass media campaigns.

- The national programme collaborated with the Ministry of Education, UNICEF and UNESCO to revise the Health and Family Life Education (HFLE) curriculum in primary and secondary schools and the pilot of this curriculum in 24 schools. The Ministry of Education also developed an early childhood HFLE curriculum for the first time.

- There is an increased cadre of community peer educators and targeted intervention officers who have been trained in conducting risk reduction conversations and other targeted approaches.

- A randomised control trial was implemented in Kingston and St. Andrew using the findings from the PLACE (Priorities for Local AIDS Control Efforts) research Interventions were conducted in sites where persons meet new sex partners. The PLACE interventions utilised both evidence and theories to inform the specific strategies. The strategies used in this intervention have been rolled out to the four health regions.

- Development and placement of mass media campaigns had messages to address prevention of mother-to-child transmission (PMTCT), adherence to ARVs; abstinence, and condom-use among sexually active young men. Three anti-stigma campaigns were developed: “Live Positive,” which featured national personalities endorsing the stigma reduction messages; “Defend This” which focussed on reduction of stigma and discrimination in the workplace; and “Getting on With Life” which put a face on HIV by highlighting two persons living with HIV.

- Multimedia and social marketing efforts were also utilised to raise awareness about HIV and promote safer behaviour. These efforts included two 20-minute docudramas: “Wrap It Up” for sexually active males 15-19 years and “Fi Real” targeting females and risk perception. Several posters and brochures, targeting adolescents, were developed with messages that addressed abstinence and every-time condom.

- There were several targeted interventions to key population groups.

- Performing arts and peer education are being used with inmates of the correctional institutions.

- Peer education also is a major intervention strategy for reaching other vulnerable groups of Sex Workers (SW) and men who have sex with men (MSM).

- Workplace policies were developed and implemented in five sectors including the development of the National HIV/AIDS Workplace Policy by the Ministry of Labour and Social Security. This development has also resulted in the substantial involvement of PLWHA in sector programmes geared toward sensitising workers.

- Cultural vehicles are being used to reach adolescents and adults aged 15-29 years old. Through partnerships with party promoters and condom marketers, interventions have been conducted at parties to increase condom access and usage skills.

- Prevention messages have been endorsed and presented by various local artistes via advertisements in electronic and print media or personal appearances at organized adolescent interventions.

- The programme has strengthened its reach to adolescents and other vulnerable populations through its partnership with several NGOs. Partnership efforts include:

- The Jamaica AIDS Support for Life has been involved with outreach and interventions with the MSM community.

- Children First's mobile Bashy Bus conducts edutainment prevention messages and provides basic health services to children living and/or working on the street and other hard-to-reach young people.

- Development of training package (containing manual, video and posters) focussing on prevention of HIV/AIDS among persons living with mental disabilities and training of adolescents and young people with disabilities implemented by 3Ds with technical and financial assistance from UNICEF in 2005.

- The Jamaica Red Cross implemented training for peer educators in schools island-wide.

- The national programme launched a website to provide information to the general population.

Challenges

Although the majority of persons report condom use with a non-regular sex partner there has been no further change in reported safer sexual behaviours in the past ten years. Just about, 77% of males and 67% of females aged 15 –49 years reported condom use at last sex with non- regular partners. In addition, inaccurate perceptions about HIV/AIDS

transmission persist (such as the erroneous belief that you can actually tell by looking who has HIV). This is evidenced by the fact that only 36% of young men and 40% of young women were able to identify correctly the ways of preventing the sexual transmission of HIV and at the same time, reject major misconceptions about AIDS.

There has also been a decline in the median age of first sex from 15.7 years in males and 17.2 years in females in 2004. The 1996 KAPB revealed the median age of first sex at 16.43 years in males and 18.2 years in females. The survey conducted in 2000 recorded this at 15.5 years for males and females 17.5 years.

In addition, high-risk behaviours such as having unprotected sex, multiple sex partners and sex with SWs were reported by a significant portion of the general population. In 2002, about 27% of those aged 15-24 who was married or with a common-law partner, had sexual relations with more than one partner. Nearly half of those with a 'visiting partner' had sexual relations with more than one partner (RHS 2002). Moreover, there has been an increase in reported sex with SWs over the last decade.

In assessing the reported behaviour change interventions developed by the National HIVSTI Programme over the past fifteen years, most of these interventions have been directed at the individual and interpersonal level. Although strategies have been guided by the behaviour change theories, insufficient attention has been given to constructs that highlight the need for changing or impacting the environment. This is not indicative of lack of awareness among planners regarding the importance of the environment in providing a context to facilitate or hinder behaviour change, but rather it highlights the limitations that can result when healthy behaviours are being promoted in a resource challenged and policy constrained situation. The individual is being challenged to change behaviours yet the economic and cultural context in which he exists does not support the behaviour due to economic pressures and cultural norms and values.

In Jamaica, approximately 20% of the population lives below the poverty line. These persons experience an increased vulnerability to HIV infection because making safer healthy choices sometimes conflicts with decisions for daily survival. Therefore despite a high level of knowledge and attempts at practicing the new behaviours, the behaviours are not sustained as they are usually in conflict with choices for daily existence, gender norms and the constantly evolving sub cultural norms and values.

Prevention interventions need to extend beyond the individual and the interpersonal to execute strategies that mobilise other players who critically impact the environment. These strategies must of necessity include the social agencies as well as those organizations that are responsible for the economic development that translate into employment opportunities for those below the poverty line. Interventions must also be cognizant of gender related issues that impact the practice of the desirable safer behaviours. In addition there has to be capacity building within the sectors as it relates to both technical and human resources in order to achieve a multiplier effect thus scaling up coverage.

Interventions that have been conducted with modest levels of success will be replicated on a larger scale. In order to identify the more effective interventions research will be conducted with differing audiences as well as evidence–based interventions will be scaled up. Specifically some lessons have been learned from the PLACE random control trial. These approaches that addressed the need to intervene at the environmental, group as well as the individual levels will be replicated. Strategies to secure a wider societal involvement will also be implemented as this is of particular importance in reshaping cultural norms relating to risky sexual behaviours.

Social Vulnerability and Gender: The risk of HIV infection can be directly attributed to the individual's risk behaviours that increase vulnerability as well as the social context in which the individual operates. In Jamaica there are different spheres of vulnerability impacting on the individual. First there are those who are new players – such as, young people who have not yet acquired the information and the skills to effectively address the threat of HIV/AIDS. These populations will have to be supported and given the tools to effectively protect themselves. Another issue of social vulnerability is the economic situation in which the individual lives. Some persons are at the lower end of the social economic scale hence daily existence is a challenge. These individuals may be forced to make choices that put them at risk of HIV, as they are not in a position to negotiate or insist on safer sex. Issues of gender also increases social vulnerability as girls who are teenage mothers have their education terminated or interrupted hence they are at an academic disadvantage and are unable to secure employment or high paying jobs on a regular basis. The young female usually ends up with repeated pregnancies as a result of her desire to secure support for her child and herself. The young male on the other hand might not have to terminate his education. There are however, various social norms that he has to struggle to conform with and without adequate mentorship and support he is likely to succumb to the pressures to conform. Traditional gender roles also can potentially impact the male's decision to reduce partners or to use protection. It is commonly believed and entrenched in the society that the man should have more than one partner, should become the father of several children, and be heterosexual. All these are seen as indicators of the 'real man'. It becomes very difficult for the man who desires acceptance from his peers as well as within his community to practise safer sex and reduce risk of HIV infection by using condoms and reducing the number of partners.

Infrastructural and service weaknesses across sectors add to these behavioural and societal challenges. Within the health sector, for example, there is a perceived lack of tolerance and respect for certain categories of clients and hence quality assurance is undermined. In the education sector, school guidance counsellors do not provide adequate sex and sexuality counselling. Slow procurement procedures and salary freezes further exacerbate these issues.

Sector-Related Issues: While there are clearly strides made by each of the sectors, each government ministry is faced with its own set of unique challenges. For the Ministry of Tourism, for example, engaging small hotels is a difficult task. None of the hotels allow condom vending machines to be placed in common bathrooms or in hotel rooms. For them, placing condom vending machines is more appropriate for staff quarters. It is also

difficult to engage hotel staff for the amount of time necessary to make an impact whether during training or an actual sensitisation intervention by trainees. Challenges for the Ministry of National Security, for its part, include the persistence of stigma and discrimination despite the integration of HIV/AIDS courses into the existing trainings for police, correctional officers and agents. To receive the required meaningful sector response, there is insufficient ownership at the ministry level as programme implementation and reporting are held together primarily by Programme Officers placed in the sector ministries, paid and recruited by the National HIV/STI Programme. There is a need for new partnerships to be developed and existing partnerships strengthened. The lack of coordination between and within the health sector and NGO agencies creates a system of care that is fragmented and sometimes duplicative. There is also a clear need to involve new partners private schools, women's organizations and incorporate prevention activities in poverty reduction programmes.

The Way Forward

Given what is known about what works in terms of prevention efforts and the existing prevention needs, the priority focus for 2007-2012 will be:

Knowledge, Belief and Behaviour Change: The initial results of the behaviour change communication interventions have shown an increase in knowledge and change in beliefs regarding HIV and AIDS. Future efforts guided by outcome assessments should include dispelling myths associated with transmission of HIV, appropriate risk assessment and change in risk behaviours that is: consistent condom use, delay in initiation of sex, and reduction of stigma and discrimination.

Research-based prevention efforts: It is clear that additional resources must be dedicated to research-based prevention efforts. Lessons learned from PLACE and targeted community and population interventions must be used to efficiently and effectively change behaviour. Where more information is needed to understand a population, such as SWs, MSMs and those who engage in transactional sex, participatory community-based research should be conducted.

Risk reduction conversations: The prevention programme has shifted the focus of interventions from information giving and sensitisation to risk-reduction interactions**.** This means that interventions have to go beyond one-time events and one way dispensing of advice and information to the meaningful engagement of the various audiences in activities that confronts the individual and assist him or her to make a decision for a change plan. It is also vital that these interventions have a focus on building self-efficacy.

Building capacity: Outreach workers, peer educators and other health education personnel have to be trained in the use and promotion of risk-reduction interactions. They also must be willing to change how they work. There is an urgent need to reorient programme planners and interventionists both in the health and NGO sectors to implement interventions that are geared beyond the giving of information to engaging individuals in interactions that are more likely to result in accurate personal risk

assessment and empowerment of the individuals to practise the recommended behaviour. This type of change is not easy and staff must be given support and monitored closely.

Prevention is the responsibility of all sectors of society: It is also critical to recognize that prevention is not solely the responsibility of the Ministry of Health. All public and private sectors must be fully committed to prevention efforts. Effectively engaging bars, clubs and hotels is one of the major challenges facing the national response effort. Each establishment should have an education programme in place and a method to distribute condoms.

The role of the Ministry of Education: Children and **y**outh must be reached more effectively through an enhanced Health and Family Life Education (HFLE) curriculum and through new partnerships with private schools. A comprehensive HIV/AIDS programme must be developed for the sector and this extends to the tertiary level. It is recommended that a whole institution approach be taken when implementing this programme and that there be emphasis on life skills that better prepare the students to make informed choices with regard to sexual and reproductive health.

Drug abuse: The issue of drug abuse particularly as it relates to crack and cocaine use among street sex workers as well as other emerging groups will have to be addressed through close collaboration with the National Council on Drug Abuse and possible collaboration with the NGO community. Interventions with this population will have to focus on addressing addiction as well as the immediate issues of practicing safer sex i.e. improving access to prevention methods.

Vulnerable populations: Prevention interventions to reach these groups primarily men who have sex with men, sex workers and adolescents have to be evidence based and not only seek to address the individuals but also the context in which they practice the behaviour. It is imperative therefore that clients, partners, parents, gatekeepers and other stakeholders are reached as part of the interventions. Particularly in relation to the sex workers and the MSM group, issues of stigma and discrimination has to be addressed in order to increase willingness to access the public health services. Condom negotiation skills, building self-efficacy, increasing condom access has to be included in interventions to reach this population. Additionally increased effort is needed to reach sex workers in the more discrete locations such as massage parlours and other non-traditional sites. For adolescents especially those made vulnerable by being out of the formal school settings, interventions must address condom access, access to risk reduction information and building self efficacy. Adolescents in state institutions should be specifically addressed to increase their knowledge base of sexual reproductive health issues.

Marginal group of non-condom users: Twenty five percent of men and 34% of women have reported non-condom use with non-regular partners. This persistent risky behaviour requires intensified strategies that consistently impact the individual, the group and the environment levels. Techniques of motivational interviewing could be adapted in

behavioural interventions to reach this group. Further research is also needed to gain more insight into these persistent risk behaviours.

PLACE Interventions: Important lessons have been learnt from the research phase and from the randomised control trial and will be applied to interventions being conducted at the in-country regional level and within the NGO sector. Of particular importance are lessons relating to structured monitoring and evaluation of the quality of the intervention as well as approaches to initiating interactions in the outreach settings, that is, socializing sites, club bars, sex work sites and communities.

Cultural Norms: Existing cultural norms support and reinforce risky sexual behaviours especially as it relates to multiple partners, early sexual initiation and a seemingly assumed docility among females pertaining to sexual decision making. Individuals who influence the cultural norms have to be engaged in creative and rewarding ways to use their influence to create a shift in the cultural norms. These influentials are positioned in entertainment, media, sports, religious and other spheres both at the national and local level, sports, religious and other spheres. Market Leaders in telecommunication have to be specifically challenged to initiate or support innovative strategies using the technology to influence positive behaviours especially among the youths.

Youth Empowerment: Young people between the ages of 10 – 24 years old have to be motivated and challenged to become involved in planning and implementing programmes to reach other young people. They need to be equipped with the prerequisite skills that allow them to exercise control over their sexual and reproductive health and to influence their peers to make similar positive decisions.

Positive Prevention: Positive prevention interventions reduce re-infection for the PLWH and protect sexual partners. Persons living with HIV and AIDS have to be supported to practise positive prevention. This includes providing skills for partner sexual communication that can lead to disclosure as well as basic skills in practicing safer sex. It is imperative therefore that a supportive environment for disclosure be created. Strategies to further reduce stigma and discrimination have to be intensified. The PLWH community and in particular the NGOs have to take the lead on this issue in collaboration with the national programme for capacity building and skills transfer and monitoring mechanisms.

Labour Sector: The workplaces are important settings to reach a significant portion of the sexually active population. The involvement of the tripartite team of government, employers and workers represented by the Ministry of Labour and Social Security, the Jamaica Employers Federation and the Jamaica Confederation of Trade Unions will need to continue mobilising the entire sector via implementation of strategies that affect knowledge and reject myths and reduce personal risk behaviours. The need for ongoing interventions in the sector will have to be undertaken by individuals within the sector who have responsibility for human development. The national programme will support skills building in the specific technical areas.

Tourism Sector: A more realistic approach is needed in this sector to address the challenge of condom access within the sector. The various stakeholders will need to examine creative approaches to secure the commitment of operators of small hotels and some of the larger properties to further challenge individuals to change behaviours.

Mass Media: The continued engagement of the media in maintaining the issues relating to HIV/AIDS on the public agenda is needed. Additionally the media alliance needs to be expanded and strengthened to improve the reach to selected audiences. The media alliance is also well placed to influence an environment that can result in the shifting of cultural norms that are more supportive of prevention practices.

Gender and Social Vulnerability: These issues are pivotal in seeking to address risk reduction behaviours. There is need to increase the awareness of the national programme team and its partners about the need to develop gender specific interventions and to build their skills to practically integrate gender issues in existing interactions.

2. Treatment and Care

Jamaica is far advanced in implementing an extensive system of care that includes HIV voluntary counselling and testing, diagnostic services, counselling, psycho-social support and the provision of specialized clinical care inclusive of access to antiretroviral medications. However significant gaps still exist which hinder the timely achievement of universal access to high quality care. A systematic approach focusing on integration of HIV/AIDS care within the general health services and support systems will aid in ensuring sustainability.

Achievements

Screening and Diagnostic Services

- A voluntary counselling and testing site has been established in all major health centres with over 95% of relevant staff (Contact Investigators, Social Workers, Public Health Nurses, etc.) trained in VCT protocol.
- HIV testing is decentralized with each region having the ability to carry out HIV test results without having to send samples centrally to the National Public Health Laboratory (NPHL).
- HIV rapid testing was introduced in some peripheral clinics allowing same day results in some instances.
- Provider initiated testing has been introduced at major hospitals.
- CD4 testing facilities along with automation and sample preparation systems have been established in Kingston at the National Public Health Laboratory and in St. James at the Cornwall Regional Hospital.
- Currently, CD4 counts are available to PLWHA at a reasonable cost for those who can afford it and free to those who cannot.

Prevention of Mother-to-Child Transmission (PMTCT)

- The PMTCT programme was developed and implemented using Zidovudine/Neverapine
- A new protocol HAART was developed and preliminary steps towards implementation.
- Implementation Guidelines for Health Care Workers "PMTCT+, Integrating Treatment Care and Support with Prevention of Mother-to-Child Transmission of HIV Services" was developed by NHP and MOH with technical and financial support from UNICEF (2006).
- Antiretroviral (ARV) treatment for the Prevention of Mother-To-Child Transmission (PMTCT) was provided to 75% of HIV-infected pregnant women and 85% of HIV-exposed infants (2005).

HIV screening for access to ARV for HIV positive pregnant women is in place for 90% of public sector Antenatal Clinic attendees (28,000 in 2004 compared to 4,000 in 2002) and more than 50% of STI Clinic attendees (19,000 in 2004).

The programme provides RNA-PCR tests for infants of HIV positive mothers allowing for early diagnosis and treatment of paediatric AIDS.

Post-Exposure Prophylaxis
A training manual was developed and antiretroviral drugs are available and accessible in all regions for the prevention of HIV transmission to accidentally exposed health care workers.

Limited quantities of waste disposal supplies and personal protective equipment have been provided at some HIV treatment sites to augment mainstream supplies.

Medical Management

Most of the relevant health care workers have been trained in the management of STI and Opportunistic Infection (OI); and drugs have been procured and distributed to all regions for the treatment of OIs and STIs.

- A manual on the nutritional management of HIV/AIDS was developed by the Caribbean Food and Nutritional Institute (CFNI) and the Canadian International Development Agency (CIDA)
- Eighteen treatment sites (paediatric and adult) were established across the island with trained team of providers in each facility
- There is a partnership with private physicians to enable the treatment of PLWHA in private setting.
- More than 2500 adults and children have been started on ARVs, in accordance with national guidelines.
- Guidelines for the clinical management of HIV/AIDS were developed (2^{nd} edition being developed at the time of writing)
- Several training programmes have been conducted for all categories of health care workers (including Pharmacists, Doctors, Nurses, Social Workers Contact Investigators, Adherence Counsellors etc.) in clinical management of HIV/AIDS.
- The Annual HIV/AIDS Clinical Management Workshop has been institutionalised through the Caribbean HIV/AIDS Regional Training Network (CHART).

Challenges

While much has been accomplished, there are still a number of challenges. In order for HIV/AIDS treatment care and support to be sustained and fully integrated within the mainstream health services the following challenges must be addressed:

Voluntary Counselling & Testing: It is estimated that potentially 15,000 persons who are HIV infected do not know their status. This represents 60% of the total number of infected individuals in Jamaica. Young people 15-24 years old are less likely to be tested than those aged 25-49 years. Less than half of SWs have been tested in within a 12-month period and know the results. Only about 10% of hospital admissions are being tested for HIV, and even smaller percentages from Family Planning and other regular clinics. Confirmation of results at the NPHL is grossly inadequate with results taking months at times with frequent reagent stock outs. Standardized database for the capture of HIV testing data has not been widely implemented.

Treatment: In 2006, more than 2,500 adults and children were receiving antiretroviral treatment in Jamaica, a dramatic increase from 2004. Yet there is still much work to be done. It is estimated that 4,000 persons are still in need of ARV. The treatment programme is estimated to reach approximately 6000 by the year 2012. Moreover, two out of three persons infected with HIV seek medical care at a late stage of the disease when the efficacy of treatment and the level of recovery attained may be limited. Individual adherence to medication also is a major challenge and may limit success of the treatment programme. Poor sequencing of ARVs by some physicians and the lack of resistant testing also needs to be addressed.

Diagnostic Services and Laboratory Capacity: Although the laboratory has played a significant role in the programme, the structure and management of the existing lab services hinders efficiency. The capacity to provide CD4 and Viral Loads in accordance with International Treatment Guidelines is still limited. Additionally, the capacity to diagnose TB and track resistance to ARVs also is lacking.

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

Resurgence of Syphilis: While there has been a significant decline in the prevalence of syphilis in the millennium decade, in 2006, health officials reported a small but significant increase in the rates of congenital syphilis and syphilis among pregnant women and as well as among STI clinic attendees.

TB Screening: The screening of HIV infected persons for TB has been limited. There is also inadequate follow up of TB contacts and individuals completing therapy in the communities. The diagnostic capacity for TB is limited and centralized with limited surveillance for multi drug resistant TB.

The lack of a clear strategy to deal with issues facing orphans and other children made vulnerable due to HIV and AIDS: An estimated 5,100 children have lost one or both parents to AIDS. However, a Rapid Assessment of the Situation of Orphans and

other Children Living in Households affected by HIV/AIDS (2002) estimates that up to 20,000 Jamaican children are affected by the epidemic. Many of these children are born in situations of poverty, thereby increasing their vulnerability to risky sexual situations (including sex work and transactional sex), involvement in criminal activities and other anti-social behaviours as a means of survival. The current lack of coordination in the provision of social safety nets for families affected by HIV and AIDS severely impedes the families and individuals ability to adequately care for and protect their children. Unfortunately, it is difficult to provide services for children orphaned or made vulnerable due to AIDS as there is no system in place to track them and determine their needs.

Procurement process: The procurement process required for goods, particularly drugs and diagnostic equipment is too long. This process, taking a minimum of six months, at times threatens the viability of the programme and hinders the meeting of targets in a timely manner.

Staff shortages: There is also a severe shortage of human resources in the field and this may be one of the greatest limitations to programme success. The lack of adequate numbers of Medical Officers of Health to manage the programme in the field as well as the general shortages of doctors, nurses, social workers and counsellors limits the programme's reach. The lack of routine testing throughout the health system, limited integration with existing health and family planning services, and inconsistent implementation and monitoring of the policies and plans are in part due to this shortage.

The Way Forward

The purpose of the treatment care and support component is to achieve universal access to high quality comprehensive treatment care and support in an environment that is non-discriminatory and supports adherence. Discrimination reduction strategies will be integrated into all interventions. The priority focus for the 2007–2012 period in treatment, care and support will be:

HIV Testing: Provider initiated testing of hospital admissions and those attending for services within the public and private sector must be prioritised. Voluntary, counselling and testing (VCT) efforts must be encouraged at family planning clinics, Type III Health Centres and within prisons. Civil society, peer counsellors and outreach workers, also have an important part to play in working with authorised sources to offer VCT. These partners must be trained, provided with logistical and technical support and monitored for quality assurance. Realistic testing protocols must be developed, implemented and monitored. Outreach activities for those most at risk, such as sex workers, MSM and others, should seek to incorporate rapid HIV testing. The data developed to capture this information will also be more fully utilized Finally, a comprehensive mass media campaign should be implemented that raises public awareness regarding the importance of voluntary counselling and testing.

Lab capacity: Focus will be placed on building laboratory capacity in the regional labs inclusive of the diagnosis of opportunistic infections. TB lab will be improved inclusive

of modern methodologies for culture of TB and other Mycobacteria. The capacity to carry out CD4, Viral Loads and other supportive investigation must be improved. Also, the capacity for resistance testing for Anti TB and HIV drugs will be explored with a view to providing resistance testing in appropriate settings as well as to allow for surveillance.

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

- Retraining of Public Health Nurses and Midwives to adopt the updated protocol PMTCT+ in 2006
- Screening of all HIV positive pregnant women with CD4 Counts.
- Ensure all women testing positive receive appropriate antiretroviral therapy for prevention of mother to child transmission in accordance with revised PMTCT+ guidelines (Jan. 2006)

- Improve information sharing (M&E) between primary, secondary and national levels

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

Adherence: Adherence to ARVs and care in general will be a major focus in this strategic plan strategies will be developed to ensure all providers of care participate in a meaningful way to promote adherence.

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

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

Social support for PLWH: People living with HIV must be empowered through psychosocial support provided through partnerships with NGOs and other sector ministries. Increasing access to economic opportunities and the provision of job opportunities are important for adherence to ARVs.

Orphans and other children made vulnerable due to HIV and AIDS:

- Expansion of social support programmes, including income-generating programmes for families caring for children infected or affected by HIV. (MOLSS, CDA, NHP, NAC, JASL, Early Childhood Commission, NGO "Children of Faith")
- Nationwide implementation of interventions aimed at strengthening the capacities of parents and caregivers of children infected and affected by HIV and AIDS in order to facilitate healthy emotional development. This will also involve the expansion of access to psychosocial support within the healthcare system for children and families affected by HIV. (CDA, Child Guidance Clinics, NHP, NAC, JASL, JN+, Children of Faith, Coalition for Better Parenting)
- Improvement in database and monitoring mechanisms allowing greater follow-up and access to care and support services for children living with HIV (NHP, CDA MOLSS, JASL, ECC, CHARES, Children of Faith)

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

- Integrate expected roles and responsibilities of PLWHs into existing HIV/AIDS Policy
- Develop standardized messages geared towards encouraging responsible sexual behaviour among PLWH including adolescents living with HIV.
- Develop support groups and intervention counselling for PLWHs attending treatment sites
- Train available adherence counsellors in Positive Prevention methodologies.

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

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

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

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

- Updating and reprinting of the infection control manual, with widespread distribution
- Training of all levels of health care workers in the management of post exposure prophylaxis.
- Implementation of an alternative technology for medical waste (including sharps) management

Quality Control and Standardization: Guidelines for the management of persons infected with HIV as well as guidelines for post-exposure prophylaxis and infection control must be adopted. The National Plan of Action on Orphans and Other Children Made Vulnerable by HIV/AIDS 2003 – 2006 guided the management of children infected or affected by HIV/AIDS at community, family, service delivery and policy levels. A Paediatric Care Treatment Manual has also been developed and must be utilized. One of the future challenges is to work with both public and private providers to ensure that they are following the guidelines. Medical audits will be conducted.

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

Procurement issues: The procurement problems must be addressed and are elaborated upon in the section on Priority Area 4, Empowerment and Governance.

3. Enabling Environment and Human Rights

There are several factors within the Jamaican environment, which can inhibit universal access to prevention, treatment care and support. It is therefore necessary to establish and sustain policy positions supported by legislation to create a more enabling environment. Impeding factors fall within the ambit of (1) social and cultural norms, (2) the political environment and sensitive issues surrounding vulnerable groups and affirmation of their rights, (3) stigma and discrimination, (4) MSM-related stigma and discrimination, (5) socio-economic issues which affect principles and values espoused in the National HIV/AIDS Policy (6) a fragile foundation to promote the protection of human rights (7) intolerance for preferences and behaviour which threaten strong religious customs, and (8) the fact that HIV/AIDS is promoted as a developmental issue with little consideration for its integration into social and manpower planning and development and into poverty reduction programmes.

Jamaica has taken preliminary steps to address some of these factors by the approval of the National HIV/AIDS Policy and other sector and workplace policies. However, existing legislation does not cover all the issues and hence cannot ensure protection of the rights of all Jamaicans including those vulnerable to HIV and otherwise marginalized.

Achievements

- The Jamaican Parliament approved the National HIV/AIDS Policy in 2005.
- Cabinet approved the National HIV/AIDS Workplace Policy (March 2007)
- National Policy for HIV/AIDS Management in Schools approved by Cabinet (2001)
- Five ministries are leading critical sectors of Labour and Social Security, Tourism Entertainment and Culture, Education and Youth, Local Government and the Environment and National Security in dealing with HIV/AIDS at the workplace through sector policies and programmes coordinated by Focal Points on HIV/AIDS and HIV/AIDS Programme Officers. All other government ministries have developed HIV/AIDS workplace policies and are coordinating programmes through Focal Points on HIV/AIDS and three have the support of seconded Workplace Programme Officers.
- The tripartite team of government, employers and workers through the Ministry of Labour and Social Security, the Jamaica Employers Federation (JEF) and the Jamaica Confederation of Trade Unions (JCTU) promotes and coordinates HIV/AIDS workplace policy principles and programmes as part of the national response. Since 2004, this effort has been expanded through the establishment of the ILO/USDOL Education Workplace Programme.

- HIV/AIDS workplace sensitisation and training efforts and policies have been developed in 70 large (> 100 employees) private sector companies with 37 of them having workplace policies on HIV/AIDS.

- The Jamaica Business Council on HIV/AIDS (JABCHA) was established in September 2006 with an executive membership of 21 leading business leaders and has created a two–year work plan to engage the business sector in HIV/AIDS workplace issues.

- A local law firm was commissioned by the National HIV/STI Programme to review existing laws. The study recommended immediate amendment to the Public Health Act among others to support national policy objectives.

- A Policy/Legislative Steering Committee has been established - chaired by the Planning Institute of Jamaica – which has facilitated the preparation of a submission to Cabinet requesting amendment to the Public Health Act, HIV/AIDS specific regulations and the repeal of outdated laws such as the Venereal Diseases Act, the Leprosy Act and the Quarantine Act.
- The National AIDS Committee (NAC) provides legal assistance to PLWH and advocacy services for supportive legislation through its team of lawyers on the Legal and Ethical sub committee and lobbies for improved awareness of stigma and discrimination issues. Through the NAC, there is advocacy to and sensitisation of high-level political and private sector leaders and those of the legal fraternity.
- National Plan of Action for Orphans and Other Children made Vulnerable by HIV/AIDS (2003-2006) approved by multi-disciplinary OVC Committee chaired by the Child Development Agency and including the National AIDS Committee and National HIV/STI Control Programme.
- People Living with HIV (PLWH) participate actively in the national response and have established a network for membership that facilitates advocacy, support and capacity building.

- Mass media campaigns to improve attitudes to persons living with HIV and AIDS - "Defend This" and "Getting on with Life" have been conducted with the latter featuring a male and a female living with HIV.
- Training material including a workplace docu-drama on DVD and a workplace tool kit has been developed.

Challenges

Social and Cultural Norms: Market forces tend to support the seeming thirst for sexually explicit media and Internet messages that glamorise unprotected sex, multiple sex partnerships and early sexual initiation. Within this context, risk-taking attitudes and behaviours are supported by social and cultural norms. There is increasingly less pressure on female adolescents and the older men who lure them to change unacceptable behaviour. The age of sexual debut is decreasing and life skills messages supporting responsible behaviours such as delaying sex and condom-use if sexually active are too few to compete with adult entertainment within the reach of most adolescents. Social and cultural norms also affect access to risk-reduction interventions for men who have sex

with men through societal intolerance for this sexual practice. In addition, many Jamaicans denounce access to condoms especially to minors based on moral grounds.

Political Environment: There is little support from political and other high-level leaders for messages and interventions dealing with risk reduction and increased access to treatment and care targeted to certain at-risk groups among them sexually-active minors, men who have sex with men, incarcerated men, commercial sex workers and those in places where other forms of transactional sex are practiced. This translates to a political environment that offers minimal support for any policy position or law reform seeking to increase access to condom use and treatment for such at-risk groups.

Stigma and Discrimination: Although there has been considerable improvement in the attitudes towards persons living with HIV and AIDS, discrimination is practised even on suspicion of HIV status. Also, some private sector firms still practise HIV-screening for purposes of exclusion.

MSM-Related Discrimination: Jamaicans believe strongly that it is morally wrong and repugnant for men to have sex with men. Although men who are known to be "gay" are usually allowed to go about their business, many Jamaicans have little tolerance for MSM who appear to flaunt or promote their sexual orientation. This intolerance may take the form of verbal abuse or violence at times. MSM-related stigma and discrimination increases vulnerability to HIV and reduce access to prevention, treatment and care. The rights of MSM to access prevention, treatment and care need to be recognised.

Intolerance for preferences and lifestyles, which threaten religious traditions: It is generally perceived that protected sex interventions should not be targeted to groups, which are believed to contravene religious and moral principles. Within this context, there is constant opposition for policy and supportive legislative options to protect the rights of groups such as men who have sex with men, and commercial sex workers.

Access to Voluntary Counselling and Testing (VCT) for sexually active minors: There exists a lack of clarity on the provision of VCT to sexually active minors (those under age 16) without parental consent. This has resulted in health care workers being hesitant to test minors who either request the test or are found to be practising high risk sexual behaviours and should be counselled and offered a HIV test. Many adolescents are reluctant to inform their parents of the sexual activities and therefore are not able to know their HIV status.

Fragile foundation for protection of human rights: Jamaica does not have a strong history of support for the protection of rights especially in relation to groups perceived to contravene religious customs and mores.

HIV/AIDS as a developmental issue: While there has been increased emphasis on HIV/AIDS as a developmental issue, HIV/AIDS has not yet been integrated into social and manpower planning and poverty reduction programmes:

The Way Forward

There are a number of recommendations to protect the rights of all Jamaicans including the vulnerable and marginalized. These include:

- Law reform including amendments of existing legislation including the Public Health Act with recommendations for specific HIV/AIDS regulations and the repeal of outdated legislation such as the Venereal Diseases Act, the Quarantine Act and the Leprosy Act. (Attorney General's Office/Ministry of Health)
- Consideration of the Proposed General Anti-Discrimination Legislation (National AIDS Committee)
- Amendment of the Occupational Health and Safety Act with recommendations for all organisations to adopt an HIV/AIDS policy/education programme including non-screening for recruitment and continued employment (Ministry of Labour and Social Security/Attorney General's Office)
- Further development and implementation of workplace and sector-specific policies and programmes to protect privacy and confidentiality, to address discrimination and sustain HIV/AIDS-related workplace education. (Private sector umbrella groups including the JABCHA; the tripartite umbrella groups – JEF, JCTU, MLSS; five line (sector) ministries, other ministries and their agencies)
- Identification and support for champions for change for other law reform and advocacy, which protect the rights of all Jamaicans including the vulnerable and the marginalized. (JASL, JICHR, JFJ, NAC)
- Affirmation for Reproductive Health rights for all persons including access to contraceptives, condoms and voluntary counselling and testing services for sexually active minors following counselling and a refusal to abstain. (Ministry of Health, National Family Planning Board, Children's First)
- Promotion for a climate of tolerance, respect and affirmation of rights regardless of differences and diversity (Attorney General/Ministry of Justice; JICHR, NAC)
- Law reform to support the National Policy for HIV/AIDS Management in Schools (Attorney General's Office/Ministry of Justice, Ministry of Education)
- Condom access at public places where people meet new sexual partners (NAC)
- Enforcement of privacy and confidentiality guidelines for Voluntary Counselling and Testing and the issuing of HIV test results. (Attorney General's Office/Ministry of Health)
- Public education, advocacy and training in HIV/AIDS issues for management and employees of the Insurance sub sector (Attorney General's Office/Ministry of Industry, Technology, Energy and Commerce)

4. Empowerment and Governance

Jamaica is making sure the three ones concept advocated by the Joint United Nations Programme on AIDS (UNAIDS) is reflected in the national response to HIV/AIDS. All partners have participated in consultations leading to the preparation of this national framework – the national strategic plan. There is as yet, not enough clarity regarding the National HIV/STI Programme with its multisectoral arm the National AIDS Committee as the 'one national authority'. In addition, most partners outside of the health sector are not absorbed into the 'one monitoring and evaluation system'. The national response to HIV/AIDS is led and coordinated by the National HIV/STI Programme located within the Ministry of Health with support from partners from the wider civil society. Sustainability of the national response rests on a fragile administrative and technical structure consisting primarily of temporary and project-funded posts.

The National HIV/STI Programme and its multi-sectoral partner – the National AIDS Committee - are still perceived as health sector entities by many partners in the response. This perception exists despite the fact that Government through the National HIV/AIDS Policy has identified HIV/AIDS as a major development priority. The Government of Jamaica has also affirmed the need for a multi-sectoral response to the HIV/AIDS epidemic, recognizing that all sectors of society must be part of any solution.

Of all the sectors in any given society, the private sector has the greatest potential to have an impact on HIV/AIDS-related discrimination, which poses the greatest threat to HIV/AIDS prevention and care strategies. Through the development of workplace policies, programmes and strategies for prevention and treatment, the private sector is able to reach a large section of the population with carefully defined messages and interventions for a number of intended audiences. As a result, the National HIV/STI Programme made deliberate efforts to engage the private sector and the business community in Jamaica during the last planning period 2001-2006.

With the establishment of the Jamaica Business Council on HIV/AIDS (JABCHA) in September 2006, the business sector demonstrated its commitment to work alongside the tripartite team of government, employers and workers in Jamaica to revive and sustain the business sector's involvement in HIV/AIDS workplace policy/programme development and implementation. The activities of the Jamaica Business Council on HIV/AIDS are therefore geared to create a sustainable structure that can effectively represent the business sector, while at the same time, providing value to its current members, and attracting new members that are small, medium and large operations. The Council will speak to and on behalf of business, effectively translating the national objectives to its constituency.

Achievements

Multi-Sectoral Response: The National AIDS Committee through its National Executive committee, five subcommittees and 13 Parish AIDS Associations has been

working consistently since 1988 to broaden the multi-sectoral response. This body has grown to include stakeholders from all sectors of society. Such stakeholders participate as members of the five sub committees – Legal and Ethical; Education; Fund-raising; International Development Partners; Treatment Care and Support.

Private and Business Sector - Efforts to involve the business community resulted in over 70 large (> 100 employees) companies engaged in workplace policy or programme initiatives with 30 having their own workplace policy on HIV/AIDS. The period 2001-2006 included a major milestone – the establishment of the Jamaica Business Council on HIV/AIDS (JABCHA) in September 2006. The Council comprises of 21 executives from leading business companies in Jamaica who signed their charter constitution during an official ceremony with a stated mission launched the Council.

Tripartite Team - During the period the National HIV/STI Programme ensured that the tripartite involvement of government, employers and workers are applied to public and private sector workplace activities. This has been achieved through the combined efforts of the Jamaica Confederation of Trade Unions (JCTU), the Jamaica Employers Federation (JEF), the Ministry of Labour and Social Security (MLSS) and the ILO/USDOL Workplace Education Programme.

Technical/Financial Support - Government's initiative in utilizing a loan from the International Bank for Reconstruction and Development (IBRD) and the assistance from the Global Fund to Fight AIDS, Tuberculosis and Malaria has resulted in every public sector ministry having a Focal Point on HIV/AIDS who is coordinating the development and implementation of workplace policies and programmes. Five of the ministries have been designated as line ministries in the important sectors of Labour and Social Security, National Security, Tourism, Entertainment and Culture, Education and Youth and Local Government and the Environment.

BCC Capacity Building - Behaviour Change Communication (BCC) Officers have been deployed at headquarters of the National HIV/STI Control Programme and in each of the 4 Regional Health Authorities (RHA) and are called on by other sectors to lead sensitisation and training interventions and provide technical assistance.

PLWH Capacity Building - The National HIV/STI Programme has provided technical and financial assistance to the Jamaican Network for Seropositives (JN+) – the sole entity in the country operating on behalf of members living with and affected by HIV and AIDS.

Treatment Access - Government has taken steps to locate easier access to treatment within the National Health Fund (NHF) by requiring all persons on treatment to have an NHF card which enables them to get ARVs if they are unable to pay the required J$1,000 per month fee.

Parliamentary Support - Parliament in 2006 approved the Report of the Joint Select Committee on Human Resources and Social Development On Its Deliberations on HIV/AIDS in Jamaica.

Challenges

Multisectoral: (1) The government needs to establish posts for programme staff in order to ensure sustainability. (2) The concept of the National HIV/STI Programme within the Ministry of Health as the "one national authority" needs to be recognised among stakeholders and partners. (3) There is limited financial commitment from non-health sectors to plan and implement HIV-related strategies. (4) There is limited involvement of high-level leaders or 'influentials' from civil society. (5) Private sector has accepted the ILO principle of non-screening for recruitment and continued employment, but does not adhere to this consistently in practice. (6) In general, NGOs working in the field of HIV/AIDS have limited financial and technical capacity. (7) Churches and faith-based groups need to accept the reality that members of their congregation are also at risk of HIV infection and need to be better prepared to address this.

Procurement: The Government of Jamaica's procurement process often runs counter to the procurement policies of several international donor agencies and as such results in major delays.

Sustainability: The execution of the programme requires significant administrative and technical input of medical officers, behaviour change communication officers, social policy officers, social workers and counsellors and other health care workers. The programme's operational structure includes only two government permanent positions as compared with 230 temporary positions offering technical and administrative competencies (*See Figures 3 and 4*). There is a lack of Government of Jamaica funds for sustaining the programme after funding from external sources ends in 2008. Three main sources provide financial and technical resources for the national response - the Government, the World Bank through a loan agreement; and grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria and the United States Agency For International Development. Short-term grants also come from other international agencies with a resident office in Jamaica. The infrastructure of the Health Sector's regional health authorities is not able to handle the increasing demands of the programme's services as they are dealing with other health related areas. Resources and processes stipulated by donors require that technical staff within the health system undertake an increasing amount of administrative tasks. In addition, partners involved in the national response include a number of community-based, faith-based and non-governmental organizations whose fledging capacity render them weak in delivering interventions in a sustainable way.

Governance, Communication and Accountability: There is insufficient clarity about the role of the National HIV/STI Programme in leading the coordination and implementation of the national response and the National AIDS Committee's role in expanding the multi-sectoral response and advising government.

THE WAY FORWARD

- Institutionalise all key posts within the National HIV/STI Programme as permanent posts within the public sector.

- Include HIV/AIDS as a stand-alone budget line item within the recurrent budget.

- Operationalise commitment to the "Three Ones" concept - one national authority, one national framework and one monitoring and evaluation system

    - This means retaining the National HIV/STI Programme as a division within the Ministry of Health and the National AIDS Committee as its multisectoral arm; ensuring that all key partners are part of the monitoring and evaluation system; and establishment the widest exposure possible for review and finalization of this strategic plan.

- Harmonize, align or remove barriers within the existing government procurement system; otherwise provide special provision(s) to allow timely implementation of the HIV/AIDS programme.

- Expand the existing Monitoring and Evaluation System to include all stakeholders and partners in the creation of one master framework that guides the national response.

- Implement and harmonise mechanisms to foster greater collaboration with stakeholders. Existing mechanisms include the Country Coordinating Mechanism (CCM) and the National AIDS Committee (NAC).
- Improve awareness among Business Sector constituents of the need to integrate HIV/AIDS into operational plans to decrease the burden on companies.
- Strengthen the capacity of public and private sector agencies and NGOs to be effective implementation partners in the national response.
- Work with religious leaders in order to promote greater tolerance and acceptance of PLWHA, address risk reduction and reduce HIV-related discrimination.

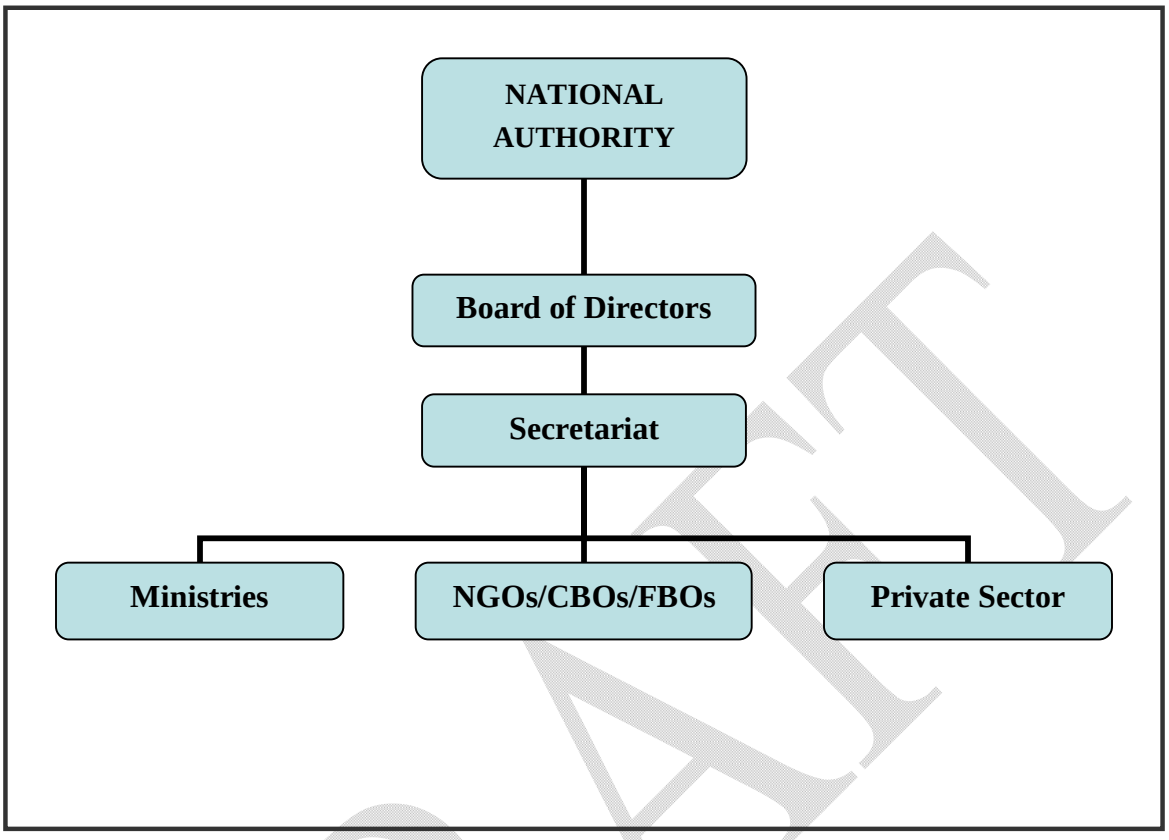
Figure 3. Structure and Positions at NHP

NATIONAL HIV/STI PROGRAMME POSITIONS	
Executive Office Chief Epidemiology & AIDS Senior Medical Officer Project Assistant Secretary	**Finance & Administration** National Programme Administrator Procurement Officer Procurement Assistant (2) Finance Officer Finance Assistant (2) Secretary
Prevention Director Prevention Coordinators (2) PLACE Coordinator Behaviour Change Communications Officer Senior Project Assistant Project Assistant (3)	**Treatment Care and Support** Treatment Coordinator Treatment Assistant
Monitoring and Evaluation M & E Director M & E Officer Information Systems Officer Research Assistant	**Policy** Policy Coordinator Project Assistant **Capacity Building** Coordinator

Figure 4. Positions in the Regional Health Authorities (RHA)

National HIV/STI Programme Current Project-funded Positions in RHAs					
Position	Regional Health Authorities				
	NERHA	SERHA	SRHA	WHRA	Totals
Adherence Counsellors	5	0	5	3	13
Administrative Assistant	0	1	0	1	2
BCC Officers	3	3	4	5	15
Clinicians	0	4	2	0	6
Community Peer Educators	12	12	18	12	54
Laboratory Technician	1	0	1	0	2
Regional Lab Coordinators	0	0	0	1	1
Programme Coordinators	1	1	1	1	
TOTAL	**22**	**22**	**31**	**23**	**93**

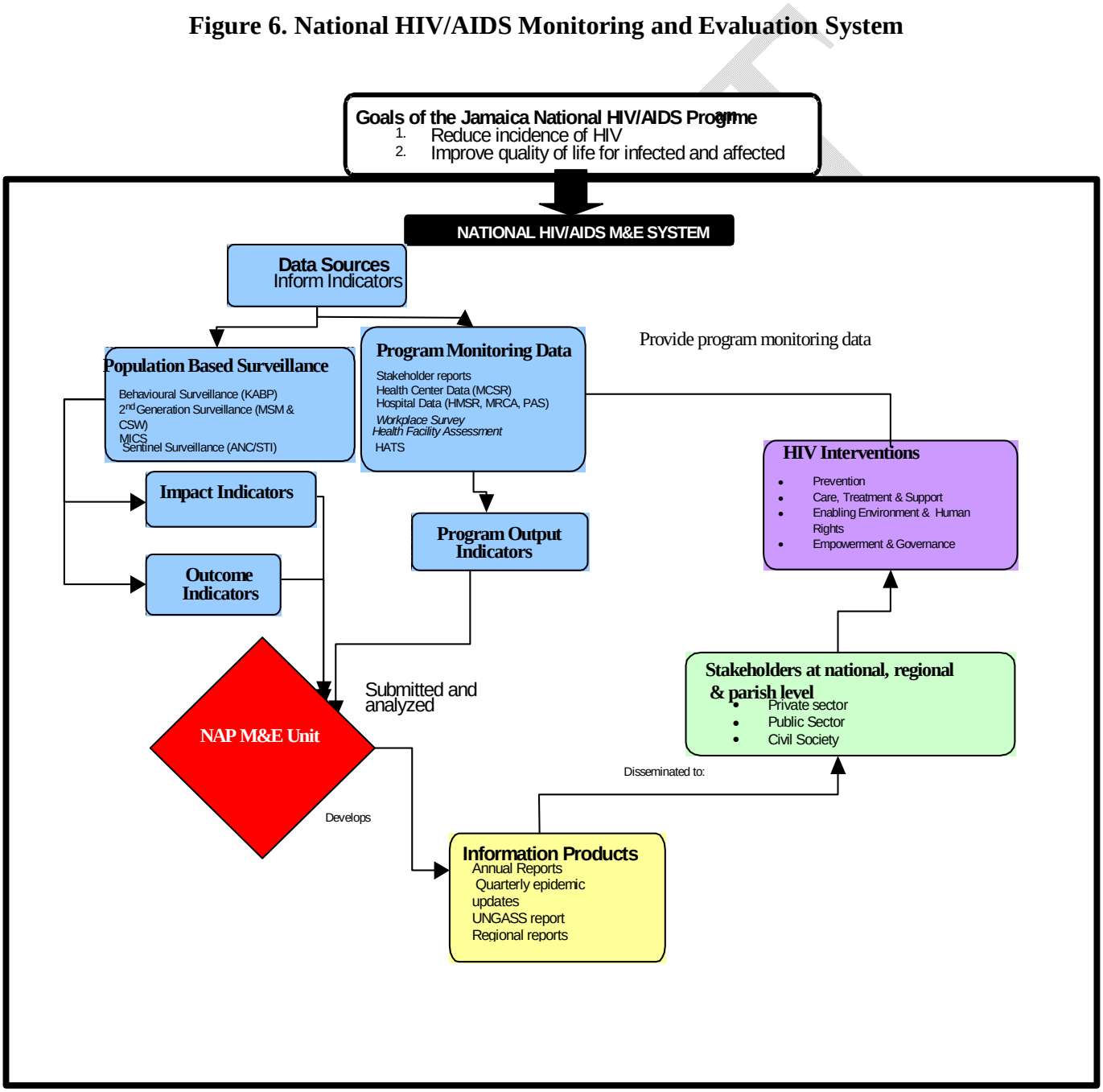
Figure 5: Proposed 'One National Authority' Organigram



IX. MONITORING AND EVALUATION

This national strategic plan lays the foundation for future activities and provides guidelines to sectors and lead agencies on how to move forward in the development of annual operational plans. The monitoring and evaluation (M&E) plan is a companion document to the 2007-2011 National Strategic Plan (NSP) and details the indicators that are used to assess the national response to HIV.

Figure 6. National HIV/AIDS Monitoring and Evaluation System



The M&E plan describes the M&E system, that is, how the expected results of the programme relate to its goals and objectives, the data needed and how these data will be collected and analysed. The plan shows how this information will be used, the resources that will be needed, and how the programme will be accountable to stakeholders. M&E plans are important because they state how the NSP will measure its achievements and provide accountability. Additionally, it provides transparency, guide the implementation of M&E activities in a standardized manner and preserve institutional memory. The M&E system is summarized below. Some elements of the existing M&E system are listed below:

HIV/AIDS Tracking System (HATS): an ongoing HIV surveillance system based on active and passive surveillance. The M&E Unit receives case reports from health services, public and private, on newly diagnosed HIV/AIDS cases. In addition, the surveillance officer based at the NHP ***actively*** visits hospitals, private practitioners, hospices, death registries, among others, to identify and complete HIV/AIDS case reports**.** Under reporting of persons infected with HIV continues to be a challenge.

KABP: a population-based survey of 15 to 49 year olds provides information on sexual behaviour (e.g. condom use, transactional sex and abstinence), practices and knowledge. This has been conducted every 3 to 4 years since 1988.

Sentinel surveillance of antenatal and STI clinic attendees: this is currently done biennially and provides data on HIV prevalence in youth and STI clients (disaggregated by age, parish and urban/rural categories).

Second generation surveillance of SW and MSM: limited data is available on many vulnerable populations. However, a survey of SW was conducted in 2005, giving insight into behaviours that fuel the HIV epidemic in this group (e.g. condom use with clients and non-paying partners, availability of condoms, access to prevention services and HIV prevalence). Surveillance of MSM will provide similar information.

Stakeholder reports: Many output indicators (e.g. numbers reached by prevention activities, number of CD4 counts done) are collated from monthly stakeholder reports, which are processed by the M&E unit.

Multiple Indicator Cluster Survey 2005

The Multiple Indicator Cluster Survey (MICS) is conducted every 5 years. Its primary objectives are:

- To provide up-to-date information for assessing the situation of children and women in Jamaica;
- To furnish data needed for monitoring progress toward goals established by the Millennium Development Goals, the goals of A World Fit For Children (WFFC), and other internationally agreed upon goals, as a basis for future action;
- To contribute to the improvement of data and monitoring systems in Jamaica and to strengthen technical expertise in the design, implementation, and analysis of such systems.

JamStats

JAMSTATS is the comprehensive national database that will be used to monitor Jamaica's National Development Plan 2030. The database reports on 157 indicators within the following sectors: Education, Health, Gender Issues, HIV/AIDS, Economy and the Environment.

Despite several advances in the current M&E system, many gaps persist:

- Implementation of data collection tools continues to lag behind programme implementation.
- Data collection tools and processes are inadequate and some HIV/AIDS-related activities are not captured by the current M&E system.
- Implementing stakeholders lack the capacity to conduct accurate surveillance and use data for decision-making. Reports are often late and not complaint with reporting requirements.

- Numerous conflicting, and often duplicative, reports and surveys are required by international organizations.
- Inadequate databases exist to support the M&E system.

The 2007-2011 National Strategic Plan (NSP) addresses these gaps through several mechanisms:

- Stakeholder capacity building to strengthen data collection processes and data use. This will include training key persons from stakeholders in M&E and facilitating adoption of the M&E plan to facilitate timely reporting and data use. The M&E unit will continue to use technical assistance to ensure the full implementation of the M&E plan.

- Assisting key partners in developing their M&E systems.
- Implementing databases such as the HIV/AIDS Tracking System (HATS) with measures to track testing indicators for stigma and discrimination.
- Establishment of one M&E framework with national indicators that informs all stakeholders.

Core indicators have been identified that track the progress of the national response to HIV and are aligned with the indicators of universal access.

Figure 7 Indicators and Targets

Indicators	Targets (by 2012)
PRIORITY AREA #1: PREVENTION	
Percentage of men and women aged 15 to 24 that are HIV infected	Remain ≤1.5%
Percentage of SW who are HIV infected	< 7%
Percentage of MSM who are HIV infected	≤ 25
Number of individuals reached through TCI disaggregated by vulnerable groups (e.g. youth, MSM, SW, prisoners, etc.)	SW: 8500 MSM:8,000 6,600 STI clinic attendees: 225,000 Inmates: 3000
Number of persons trained to provide services by client and service area	
Percentage 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	60% Men 60% Women
Percentage of young adults, 15 to 19 years old, who have never had sex	35% Men 55% Women
% of young women and men aged 15-24 reporting the use of a condom the last time they had sex with a non-regular partner	80% Men 75% Women
Percentage of SW reporting using a condom at last sex act with client	Remain >90%
Percentage of MSM reporting using a condom the last time they had anal sex with a male partner	Increase by 10%

Figure 8 Indicators and Targets

Indicators	Targets (by 2012)
PRIORITY AREA #2: TREATMENT, CARE & SUPPORT	
Percentage of adults and children with HIV still alive 12 months after initiation of ART	90%
Percentage of most-at-risk populations (youth, MSM, SW) who received HIV testing in the last 12 months and who know the results	SW 50% MSM TBD*
Percentage of women, men and children with advance HIV infection who are receiving antiretroviral combination therapy according to national guidelines	80%
Percentage of infants born to HIV-infected mothers [who are HIV-infected]	< 5%
Percentage of PLWHA on ARV reporting at least 90% adherence by pill count	80%
Ratio of current school attendance among orphans to that among non-orphans aged 10-14	Remain > 0.9
Proportion of confirmed TB cases tested for HIV	> 90%
Percentage of HIV positive TB patients who began or continued ARV during TB treatment	TBD
Incidence of congenital syphilis	15 per 100,000 births
PRIORITY AREA #3: ENABLING ENVIRONMENT & HUMAN RIGHTS	
Percentage of people 15-49 years expressing accepting attitudes towards people with HIV/AIDS	25%
Percent of reported cases of HIV-related discrimination receiving redress by setting	75%
Percentage of large enterprises/ companies that have HIV/AIDS workplace policies and programs	30%
PRIORITY AREA #4: EMPOWERMENT & GOVERNANCE	
Number of policy makers attending sensitisation workshops on HIV/AIDS/STI	Increased by 100%
Number of local organizations provided with technical assistance for HIV-related policy development	110
Percentage of schools with teachers who have been trained in the revised life-skills based HIV/AIDS education and who taught it during the last academic year	80%
Number of individuals trained in strategic information (M&E and/or surveillance and/or HMIS)	450
Percent of NGOs providing HIV/AIDS prevention, treatment, care and support services according to national guidelines/standards	Baseline TBD

*TBD = To be determined

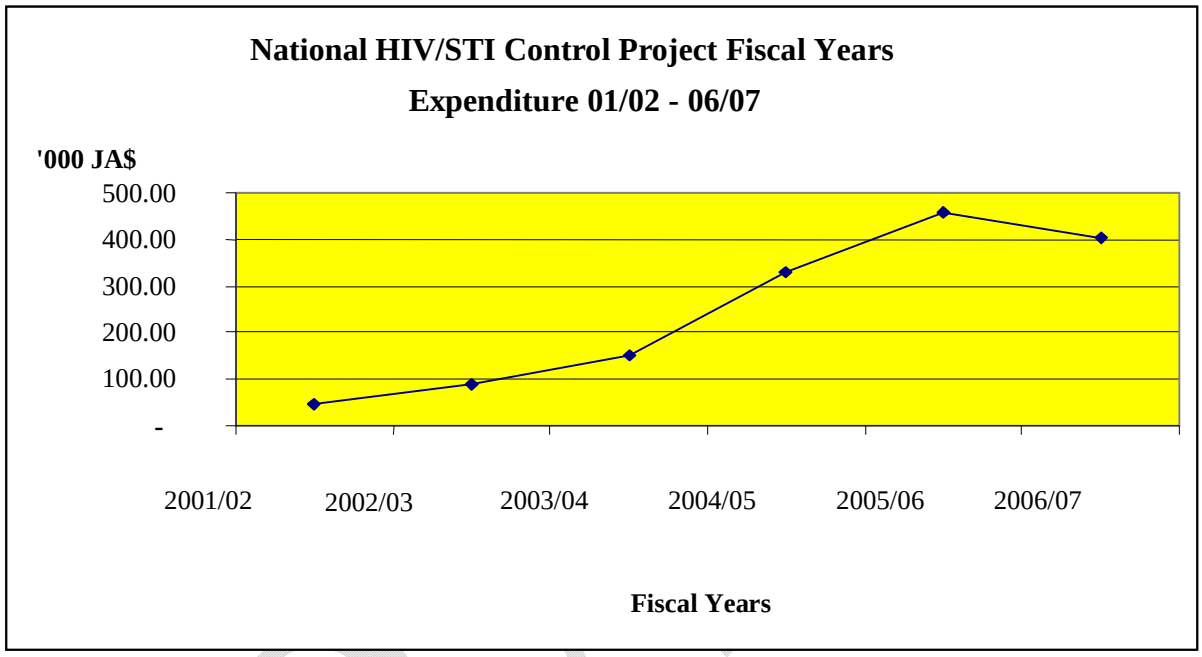
Ongoing monitoring of activities by stakeholders will provide data for indicators that will inform the NHP. Data from several sources will flow to a central processing unit and information gleaned from the M&E system will be used for better decision-making. Some forums that will be used to review indicators are the annual review of the NHP, monthly programme management meetings and stakeholder gatherings such as the Monitoring and Reference Group meetings. In addition, dissemination of data will occur through quarterly epidemic updates, press releases, and the website of the NHP. This process reinforces the role of all stakeholders in the national response to HIV and their role in a functional M&E system. Objectives and strategies will be reviewed and adapted

to strengthen the national response as implementing agencies learn and grow, and as the epidemic changes.

Financing the NSP 2007-2012

During the period 2002 to 2006, the National HIV/STI Programme (NHP) expended approximately JA$1,400 million. Expenditures increased annually over the period.

Figure 9. NHP Fiscal Years Expenditure 2002-2007



Source: Financial Statements

Four (4) funding sources primarily supported the National HIV/STI Programme (NHP). These are the Global Fund (grant), World Bank (loan), USAID (grant) and the Government of Jamaica.

Figure 10: Actual Expenditure 2005 vs 2006

Components	Actual Expenditure 2005 ('000 JA$)	% Total 2005	Actual Expenditure 2006 ('000 JA$)	% Total 2006
Treatment, Care & Support	195.18	40.2	111.286	25.8
HIV Prevention	113.308	23.3	105.964	24.6
Capacity Building	24.187	5.0	71.336	16.6
Policy & Advocacy	37.2	7.7	22.215	5.2
Administration	77.158	15.9	58.135	13.5
Others	38.619	8.0	61.604	14.3
Total	**485.652**	**100**	**430.54**	**100**

Source: Financial Statements

Costing the National Strategic Plan (2007 – 2012)

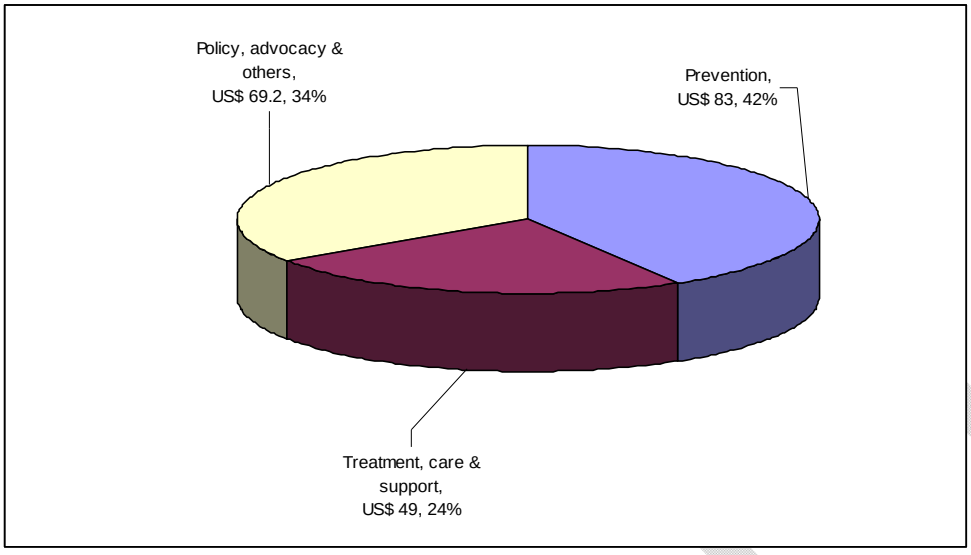
Methodology and Data

In attempting to cost the National Strategic Plan 2007-2012, focus was placed on the resources required to implement the main thematic areas of the strategic framework, namely: Prevention, Treatment and Care, Enabling Environment and Human Rights, and Empowerment and Governance. Costing calculations were based on the Futures Group Resource Needs Model (RNM). This model calculates the total resources needed for each of the component areas on a national level. The model takes into consideration three key elements: population target groups, unit costs and coverage access targets in a particular country. The costing was extended to include the cross-cutting issues identified such as policy-related issues, infrastructure, improvement in information technology and administration/management of the programme.

Results of the Costing

The National HIV/AIDS/STI Strategic Plan (2007-2012) will require US$ 201.2 million, of which 42% or US$ 83 million will be needed for Prevention, 24.3% or US$ 49 million for strategies and interventions related to Treatment and Care and the remaining 34.4% or US$ 69.2 million is the amount needed for all other remaining interventions. (Figure 11).

Figure 11: Cost of NSP Priority Interventions, 2007-2012



Within Prevention, the main cost components are summarised in Figure 12.

Figure 12: Cost of Prevention Interventions[2]

Activity	Total cost (US$ '000')	Average cost/year (US$ '000')	Percentage of total costs (%)
Youth interventions	4,164.7	832.9	2.1
Sex Workers (SW)	1,934.8	386.9	1.0
Provision of public and commercial sector condoms	32,807.7	6,561.5	16.3
Condom social marketing	7,554.5	1,510.9	3.8
Sexually transmitted infections (STIs)	6,645.1	1,329.0	3.3
Voluntary counselling and testing	1,284.7	256.9	0.6
Workplace interventions	12,631.9	2,526.4	6.3
Improving blood safety	2,024.5	404.9	1.0
PMTCT	2,479.6	495.9	1.2
Mass media campaigns	2,640.0	528.0	1.3
Men who have sex with men (MSM)	4,628.0	925.6	2.3
Community interventions	4,253.4	850.7	2.1
Total	**83,048.9**	**16,609.8**	**42**

Within Treatment and Care, the main cost components are summarised in Figure 13.

Figure 13: Cost of Treatment and Care Interventions

Activity	Total cost (US$ '000')	Average cost/year (US$ '000')	Percentage of total costs (%)
Palliative care	239.8	47.9	0.1
Opportunistic infection (OI) treatment	7,290.0	1,458.0	3.6
OI prophylaxis	70.2	14.0	0.0
Diagnostic HIV testing	7,548.0	1,509.6	3.8
Highly active anti-retroviral treatment (HAART)	33,852.0	6,770.4	16.8
Total	**49,000.0**	**9,800.0**	**24.3**

The main cost components for cross-cutting issues of policy; advocacy, programme management, monitoring and evaluation are shown in Figure 14.

Figure 14: Cost of Cross-Cutting Issues

Activity	Total cost (US$ '000')	Average cost/year (US$ '000')	Percentage of total costs (%)
Stigma reduction	2,801.4	560.3	1.4
Empowerment of PLWHA	2,094.3	418.8	1.0
Advocacy	665.8	133.2	0.3
Infrastructure (new posts)	15,750.0	3,150.0	7.8
Improvement in Information Technology	11,284.0	2,256.0	5.6
Capacity building and training	13,942.7	2,788.5	6.9
New staff hire	12,475.0	2,495.0	6.2
Line Ministries Support	583.4	116.7	0.3
Policy-related interventions	1,621.2	324.2	0.8
Administration and management	5,520.8	1,104.2	2.7
Monitoring and evaluation (M&E)	2,457.8	491.6	1.2
Total	**69,196.3**	**13,839.3**	**34.4**

Resources Gap

The estimated cost of the National HIV//STI Programme for the period 2007 to 2012 is US$ 201.2 million. Available current and planned resources cost US$ 65.7 million. Unmet resource needs are calculated at about US$ 135.5 million. This represents a financing gap of 67.3% (Figure 15).

Given the large financing gap, additional resources have to be mobilised in order to sustain the gains achieved by the National HIV/STI Programme. In particular, approval of Global Fund Round 7 proposed resources are needed to reduce the identified financing gap. In addition, the support of other donors, including USAID and World Bank will be required in the scaling up their respective support to the national HIV/AIDS response. This additional support will ensure that the national programme has adequate resources to accomplish set targets. The Government of Jamaica and the private sector are also urged to increase support financing of HIV/AIDS interventions as part of a resolute multi-sectoral national response.

Figure 15: Estimated Financing Gap, 2007-2012

Cost category	Actual (US$'000)	Estimated/planned resources (US$'000)					
	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	Total
(A) Total costed NSP resource needs	26,627.0	38,858.7	37,651.2	39,716.9	41,100.1	43,918.3	201,245.2
Less:							
Expected domestic resources (GoJ & private sector)	2,430.7	4,715.4	1,530.0	4,180.0	3,080.0	2,530.0	16,035.4
Expected external sources	3,530.7	5,533.9	11,615.2	11,018.0	11,100.9	10,428.7	49,696.7
(B) Total current and planned resources	5,961.4	10,249.3	13,145.2	15,198.0	14,180.9	12,958.7	65,732.1
Resource gap (A-B)	20,665.6	28,609.4	24,506.0	24,518.9	26,919.2	30,959.6	135,513.1
Gap as % of needs	77.6	73.6	65.1	61.7	65.5	70.5	67.3

The UN General Assembly Special Session (UNGASS) on HIV/AIDS categorised Jamaica as a middle level country based on its the HIV prevalence of 1.5%. Greater mobilisation of additional resources in the amount of US$ 201.2 million, should put Jamaica's expenditure coverage on HIV/AIDS within comparable ranges with other middle-income countries.