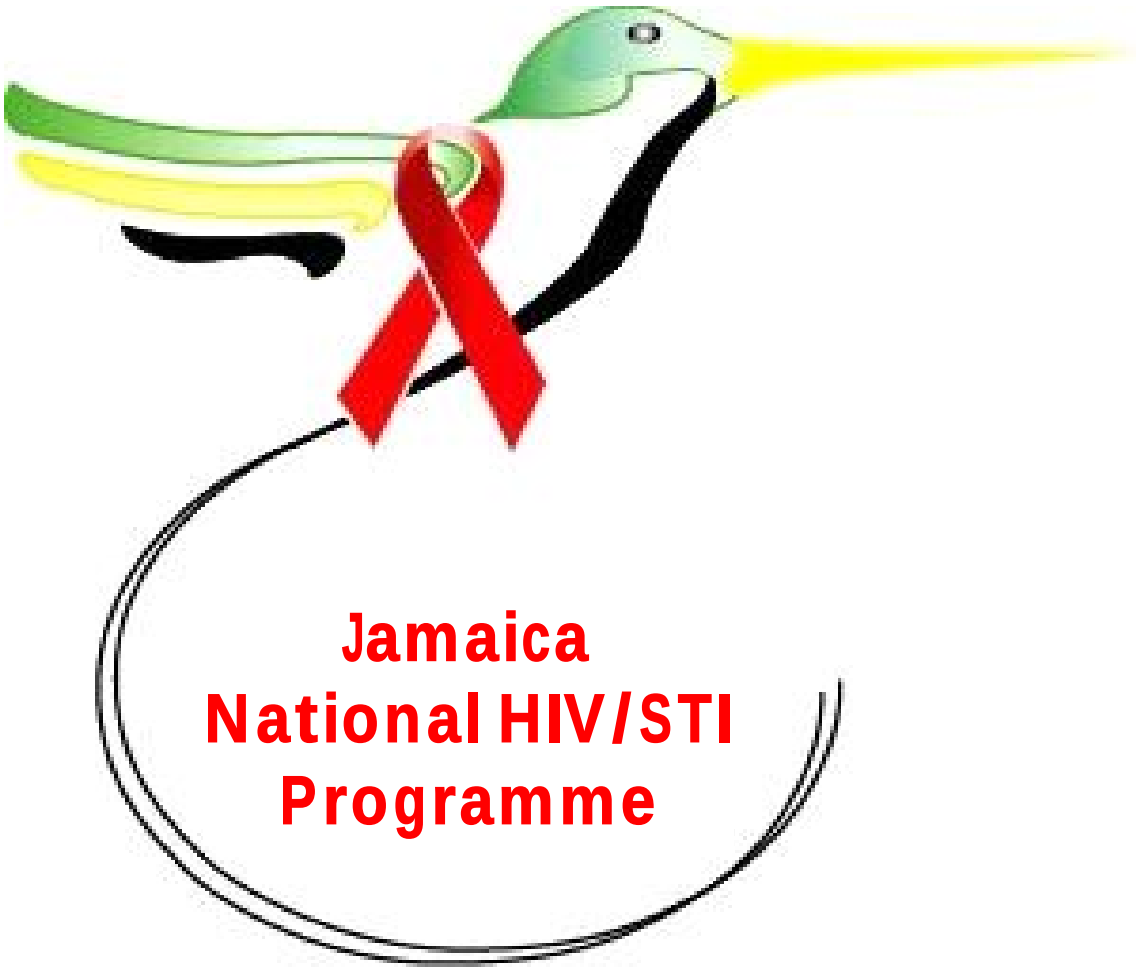
Jamaica
National HIV/STI
Programme

National HIV/STI Programme, Jamaica

Country Progress Report

To the Secretary General of the United Nations

On the United Nations General Assembly Special Session

Reporting period: January 2008–December 2009

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Ministry of Health

Jamaica

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The submission of the UNGASS report would not have been possible without the contributions and efforts of all stakeholders in the national response to HIV. Therefore we wish to extend sincere thanks to all involved for their efforts in timely and accurate reporting of data.

ACRONYMS

**AIDS** ……Acquired Immune Deficiency Syndrome

**ANC**……..Antenatal Clinic(s)

**ART** ……Antiretroviral Therapy

**ARV** ……..……Antiretroviral

**CRIS** ……..……Country Response Information System

**GAMET** ……Global HIV/AIDS Monitoring and Evaluation Team

**HFLE** ……Health and Family Life Education

**HIV** ……..……Human Immunodeficiency Virus

**IDP**.....International Development Partners

**JN+** ……...Jamaican Network of Seropositives

**KABP**……Knowledge, Attitudes, Behaviour, and Practices

**M&E** ……Monitoring & Evaluation

**MEASURE** …….....Monitoring and Evaluation to Assess and Use Results

**MERG**……...Monitoring and Evaluation Reference Group

**MSM.** ……..Men who have Sex with Men

**MICS...**……Multiple Indicator Cluster Survey

**NHP** ……...…..National HIV Programme

**NAC**……..National AIDS Committee

**NGO** ……Non-Government Organisation

**OVC** ……....Orphans and Vulnerable Children

**PAHO**…….…… Pan American Health Organisation

**PLACE** ……Priority for Local AIDS Control Efforts

**PLHIV** ……..…….....Persons Living with HIV

**PMTCT** ……...Prevention of Mother to Child Transmission

**STI** ……..…….....Sexually Transmitted Infections

**SW** ……...Sex Workers

**UNAIDS** ……...Joint United Nations Programme on HIV/AIDS

**UNFPA**……..United Nations Population Fund

**UNGASS** .....United Nations General Assembly Special Session

**UNICEF** ……...United Nations Children's Fund

**UNESCO**…… United Nations Educational, Scientific and Cultural rganization

**UNDP**……...United Nations Development Programme

**VCT** …….....…....Voluntary Counselling and Testing

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# II. Status at a glance

In 2008, 2.7 million persons resided in Jamaica with approximately 53% of the population between 15 and 49 years old. It is estimated that 1.6% of the adult population (27,000 persons) is HIV infected with approximately 50% of persons unaware of their status and not accessing appropriate services. Higher HIV prevalence is found in populations such as MSM 31.8%, SW 4.9%, inmates 3.3% and crack/cocaine users 4.5% (Ministry of Health, Jamaica, 2008; Figueroa et al, 2008). Persistent high risk behaviours such as multiple sex partners, high levels of transactional sex, and decreasing age of sexual debut combined with poverty, gender disparities and homophobia continue to fuel the transmission of HIV in Jamaica.

The Jamaica National HIV response consists of more than 100 stakeholders from the government of Jamaica, government ministries, non-governmental organizations, private sector groups and international development partners. These stakeholders have identified 4 priority areas which are detailed in the 2007-2012 National Strategic Plan:

- Prevention
- Treatment care and support
- Enabling environment
- Empowerment and governance

Under these priority areas, ARV have been made available to 49% of persons with advanced HIV, thousands of members of our vulnerable populations (youth, MSM, SW and inmates) have been educated about prevention of HIV transmission, vertical transmission from mother to child have reduced from 25% to < 5%, novel sites have been adopted for condom distribution, mechanisms for tracking and addressing HIV related discrimination have been developed, and engagement of political leadership have improved the policy environment for matters related to HIV and vulnerable populations.

This document details the trends in UNGASS indicators, the achievements and challenges of the Jamaica national HIV response, and future directions in order to achieve the vision of the national response. This report was reviewed, discussed and endorsed by stakeholders including PLHIV and representatives from various NGOs, government ministries, regional health authorities, private sector and IDP.

Table 1. Core Indicators for the Implementation of the Declaration of Commitment on HIV/AIDS, Jamaica: *January 2008–December 2009*

| Indicators | |
|---|---|
| National Commitment & Action | |
| Expenditures | |
| Domestic and international AIDS spending by categories and financing sources | In progress |
| Policy Development and Implementation Status | |
| National Composite Policy Index<br><br>**Areas covered**: gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation | See Annex 2 |
| National Programmes (blood safety, antiretroviral therapy coverage, prevention of mother-to-child transmission, co-management of TB and HIV treatment, HIV testing, prevention programmes, services for orphans and vulnerable children, and education) | |
| Percentage of donated blood units screened for HIV in a quality assured manner<br><br>[National Target: 100%] | 100% (2009) |
| Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy<br><br>[National Target: 4800 Adults 200 Children by 2009 or 75%] | 50% (2005 – ARV Program monitoring)<br><br>53% (2006 – ARV Program monitoring)<br><br>61% (Nov 2007 – ARV program monitoring)<br><br>49% (Nov 2007 – ARV program monitoring)<br><br>-It is estimated that there are 14,000 Jamaicans living with advanced HIV in 2009 |

| | |
|---|---|
| | (Spectrum/EPP software). |
| Percentage of HIV positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission<br><br>[National Target: 85% by 2009] | 47% (2004 – PMTCT Program monitoring)<br><br>65% (2005 – PMTCT Program monitoring)<br><br>85% (2006 - PMTCT Program monitoring)<br><br>85% (June 2007 – PMTCT Program monitoring)<br><br>83% (December 2009 – PMTCT Program monitoring) |
| Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV<br><br>[National Target: TBD ] | 64% received co-trimoxazole; 72% received ART (2006 National TB program records)<br><br>-There were 25 HIV positive incident TB cases in 2006, and it appears that all who met criteria for ARV received such treatment. |
| Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results<br><br>[National Target: TBD] | Men: 12.2% Women: 18.3% (2004, KABP survey)<br>Men: 20.2% Women: 35.4% (2008, KABP survey) |
| Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results<br><br>[National Target: 50% of SW by 2012] | 43% of SW (2005 second generation surveillance of 450 female sex workers)<br><br>53% MSM (2007 MSM survey)<br><br>75% SW (2008 SW survey) |
| Percentage of most-at-risk populations reached with HIV prevention programmes<br><br>[National Target: 8500 SW 6600 MSM by 2012] | 60% of SW (2005 second generation surveillance)<br><br>This indicator was not determined in second generation surveillance of MSM and SW<br><br>Over 10,000 SW were reached in 2008 and 2009 (BCC Programme monitoring data)<br><br>Over 4000 MSM were reached in 2008 and 2009 (BCC Programme monitoring data) |
| Percentage of schools that provided life skills-based HIV education in the last academic year | 24% of 1014 primary and secondary schools (2007, Ministry of Education HFLE Program |

| | |
|---|---|
| [National Target: 60% by 2010] | monitoring)<br><br>44% (447) of 1014 primary and secondary schools (2009, Ministry of Education HFLE Program monitoring) |
| Knowledge and Behaviour | |
| Current school attendance among orphans and among non-orphans aged 10–14*<br><br>[National Target: >0.9% by 2012 ] | 0.97 Male; 1.01 Female<br>0.99 urban; 0.99 rural<br><br>(2005- Multiple Indicator Cluster Survey) |
| ** % 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<br><br>(MDG Target: 90% by 2005; 95% by 2010)<br><br>[National Target: 60% by 2011] | 38.1% of 15-24 y.o (2004 KABP); 40.2% of 15-24 y.o (2008 KABP)<br><br>Females 46.7%, Males 22.8% (2004 KABP)<br><br>Women: 59.8% (urban), 57.9% (rural) (2005 MICS)<br><br>Men: 37.4% Women: 42.3% (2008 KABP) |
| Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission<br><br>[National Target: TBD] | 26.1% of SW (2005 second generation surveillance)<br><br>(data not collected in most recent MSM and SW second generation surveillance studies) |
| Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15<br><br>[National Target:TBD ] | Men: 47.7% Women: 15.2% (2004 KABP)<br><br>Men: 56.6% Women: 15.9% (2008 KABP) |
| Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months<br><br>[National Target: M: 47% F: 15% by 2008] | Men: 48% Women: 11%(2004 KABP)<br><br>Men: 61.5% Women: 16.8%(2008 KABP) |
| Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse* | Men: 66.9% Women: 53.8% (2004 KABP)<br><br>Men: 64.5% Women: 52.1% (2008 KABP) |

| | |
|---|---|
| [National Target: None ] | |
| Percentage of female sex workers reporting the use of a condom with their most recent client<br><br>[National Target: 95% by 2011 ] | 84.2% (2005SW survey)<br><br>97% with new client<br><br>91% with regular client (2008 SW survey) |
| Percentage of men reporting the use of a condom the last time they had anal sex with a male partner<br><br>[National Target: 60% by 2012 ] | 73% (2007 survey of MSM) |
| Female and male median age at first sex<br><br>[National Target: None] | 17.2 Females, 15.7 Males (2004 KABP)<br><br>16.9 Females, 16.0 Males (2008 KABP) |
| ****** % of young women and men aged 15-24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner<br><br>[National Target: M:80% F:75% by 2011 ] | 66% Females, 74% Males (2004 KABP) |
| Impact | |
| **%% of young women and men aged 15-24 who are HIV infected (Target: 25% reduction in most affected countries by 2005; 25% reduction globally by 2010)<br><br>[National Target: ≤ 1.5% by 2009 ] | 1.1% (2004 sentinel surveillance of ANC clients)<br><br>1.5% (2005 sentinel surveillance of ANC clients)<br><br>1.3% (2007 sentinel surveillance of ANC clients)<br><br>1.0% (2009 sentinel surveillance of ANC clients) |
| Percentage of most-at-risk populations who are HIV infected<br><br>[National Target: 7% SW; <25% MSM by 2011] | 9% of SW (2005 second generation surveillance)<br><br>5% of SW (2008 second generation surveillance)<br><br>3.3% of inmates (2006, Surveillance of inmates)<br><br>32% (2007 MSM survey) |
| Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy<br><br>[National Target: 85% by 2009] | 75% (2000, ARV program monitoring)<br><br>87.6% (2007, ARV database)<br><br>91% (2009, ARV database and chart review)<br><br>2009 data collected at 5 of 19 sites, which include |

| | |
|---|---|
| | sites representative of urban/rural and large/small populations. |
| **** Targets included for Millennium Development Goals** | |

# III. Overview of the HIV epidemic

Jamaica continues to experience features of a generalized and concentrated epidemic with an estimated 1.6 % of the adult population infected with HIV and higher HIV prevalence identified among vulnerable populations such as MSM (31.8%), SW and informal entertainment workers (4.9%), inmates (3.3%), and crack/cocaine users (4.5%) (Ministry of Health Jamaica, 2008; Figueroa et al, 2008). Despite widespread scaling up of HIV testing, approximately 50% of HIV infected persons remain unaware of their status and 14,000 persons are in need of treatment.

Behavioral surveillance of PLHIV confirms that the main factors driving the epidemic since 1982 have been multiple partnerships, early sexual debut, high levels of transactional sex and inadequate condom use. For example, a 2008 national survey of the general population revealed that 38.9% sexually active respondents had multiple partner in the last 12 months, 37% of sexually active persons participate in transactional sex and the median age at first sex has trended down for girls from 17.2 years in 2004 to 16.9 years in 2008 (Hope Enterprises Limited, 2008). This is also reinforced by data on persons reported with AIDS between 1982 and 2008, in which 23.1% of persons with HIV report having sex with a sex worker and more than 80% report having multiple partners. No high risk behaviour was reported by approximately 20% of reported HIV cases and this may represent persons who report having one sex partner who was HIV infected by another partner (Table 2).

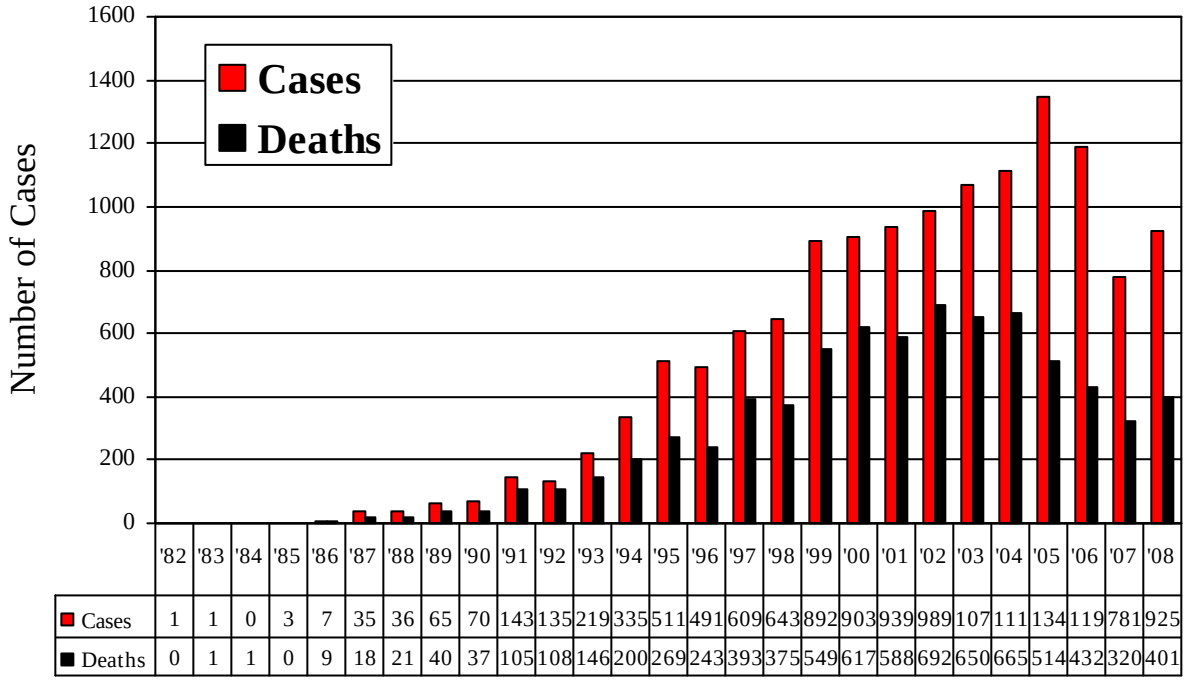
| RISK | No. of Persons (%) |
|---|---|
| Sex with Sex workers | 3384 (23.1) |
| Crack , Cocaine Use | 1089 (7.4) |
| STI History | 7528 (51.3) |
| IV Drug Use | 131 (0.9) |
| Multiple Sexual Partners/contacts | Estimated 80% |
| No high risk behaviour | Estimated 20% |

**Table 2:** Reported risk behaviour among adults with HIV with available data (1982 – Dec 2008 cumulative)

In 2008, 925 persons with AIDS were reported to the Ministry of Health (MOH) with 69% of persons in the 20 to 49 year old age group. HIV continues to be primarily transmitted through sexual intercourse, with 90% of reported cases reporting heterosexual practice. However, the sexual practice of 40% of men with AIDS is unknown and may reflect an unwillingness to reveal sexual orientation. HIV/AIDS surveillance data is also limited by incomplete reporting from private sector sources.

In response to the HIV epidemic, 4 priority areas were identified by the national response: prevention, treatment, care and support, enabling environment, and empowerment and governance. Under these priority areas, antiretroviral treatment was introduced in 2004 and the number of persons with AIDS and AIDS deaths decreased by 17% and 40% respectively between 2004 and 2008, (Figure 1). This is also reinforced by the finding in our public sector treatment sites that show the 12 month survival of persons initiating treatment in 2006 and 2007 was 80% and 91% respectively. Expansion of HIV programmes has also resulted in testing for 95% of pregnant women attending public clinics in 2009 and provision of anti-retrovirals HIV testing reduced mother to child transmission of HIV and a decline in paediatric AIDS from 61 in 2004 to 32 in 2008. The coverage of pregnant women is further reflected in a national KABP survey (2008) that revealed over 91% of pregnant women completed VCT during their most recent pregnancy. This survey includes a mix of women who have received both private and public sector antenatal care.

Despite scaling up of prevention and treatment programmes, the percent of young people**, 15 – 24 years old,** who are HIV positive, has shown no significan**t change** over the last decade (1.3% in 2004, 1.0% in 2009).




| | '82 | '83 | '84 | '85 | '86 | '87 | '88 | '89 | '90 | '91 | '92 | '93 | '94 | '95 | '96 | '97 | '98 | '99 | '00 | '01 | '02 | '03 | '04 | '05 | '06 | '07 | '08 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cases | 1 | 1 | 0 | 3 | 7 | 35 | 36 | 65 | 70 | 143 | 135 | 219 | 335 | 511 | 491 | 609 | 643 | 892 | 903 | 939 | 989 | 107 | 111 | 134 | 119 | 781 | 925 |
| Deaths | 0 | 1 | 1 | 0 | 9 | 18 | 21 | 40 | 37 | 105 | 108 | 146 | 200 | 269 | 243 | 393 | 375 | 549 | 617 | 588 | 692 | 650 | 665 | 514 | 432 | 320 | 401 |

Figure 1: AIDS Cases & Deaths Reported Annually in Jamaica (1982 to 2008)

# IV. National response to the HIV epidemic

## Policy and Legislative Framework for Prevention and Treatment

Jamaica has taken steps to create and sustain a policy and legislative framework to support the National HIV/AIDS response since 2001. Preliminary efforts began through the Ministry of Education tabling a National Policy for the Management of HIV/AIDS in Schools which was approved by the Parliament of Jamaica. By 2005 the Government of Jamaica, through its Parliament, approved a National HIV/AIDS Policy based on the ten key principles of the International Labour Organisation (ILO) in its Code of Practice on HIV/AIDS and the world of work. Lobbying and negotiation efforts of the tripartite team of the Ministry of Labour and Social Security, the Jamaica Employers Federation and the Jamaica Confederation of Trade Unions resulted in the creation of the National HIV/AIDS Workplace Policy in 2003. By 2009, a Joint Select Committee of Parliament accepted the National HIV/AIDS Workplace policy, with recommendations for its approval by Parliament along with a Manual on Life Threatening Illnesses, including HIV/AIDS.

Over the period 2002 to 2009, four line ministries developed sector policies to guide stakeholders under their purview. These included the Ministry of Tourism, the Ministry of National Security, the Ministry of Education and the Ministry of Labour and Social Security. In addition, by the end of 2009, all remaining government ministries have developed adaptations of the National HIV/AIDS Policy and the National HIV/AIDS Workplace Policy as guidelines for integration of HIV/AIDS workplace principles. All such policies have a one-year implementation plan. By the end of 2009, this process was also adopted by 181 large private sector and non-governmental organisations. The effort in the private sector was supported through the participation of the National AIDS Committee, the Jamaica Business Council on HIV/AIDS, the Jamaica Employers Federation, the Jamaica Confederation of Trade Unions, the Private Sector Organisation of Jamaica and the Jamaica Manufacturers Association. The Jamaica Business Council on HIV/AIDS was created in 2006 with 21 executive members and by 2009, had over 30 executive members. Sixteen enterprises with a solid HIV/AIDS workplace programme were guided through a four-year project supported by the International Labour Organisation between 2004 and 2008.

Of the 181 organisations including private sector companies adopting policies in Jamaica, 136 with over 100 employees have an adaptation of an HIV/AIDS workplace policy with a one-year implementation plan. Most of the organisations (179) have designated Focal Points on HIV/AIDS within their organisations who are leading the response there. In addition, 150 chief executive officers have signed a commitment for indicating their willingness to uphold the ten key ILO workplace principles on HIV/AIDS. Sixty-seven of them have established steering committees. In 2009, about 60 private sector agencies have an HIV/AIDS workplace programme.

At the end of 2008, a National HIV-Related Discrimination Reporting and Redress System (NHDRRS) was activated further. This system was established in 2007 with five simple steps: (1) Submitting a complaint about discrimination (2) Interviewing the complainant to verify the complaint (3) Investigation of the complaint (4) Redress (5) Closure. The outputs of this System are documented in the Monitoring and Evaluation Unit based on the number of cases submitted which have received some measure of redress. Between 2005 and 2009 over 180 HIV related complaints have been documented with 70% of them receiving some measure of redress.

An active National Multisectoral Group has been created since 2007 and remained active in 2009 to primarily offer guidance and recommendation for the functioning of the National HIV Related Discrimination Reporting and Redress System. This group includes organisations such as the Jamaican Network of Seropositives, the Jamaica AIDS Support for Life, the National HIV/STI Programme, the National AIDS Committee and its Legal and Ethical Sub Committee, the Independent Jamaica Council for Human Rights, the Resident Office of the Joint United Nations Programme on HIV/AIDS and direct representation from the community of persons living with HIV and AIDS.

The NAC, through its legal and ethical subcommittee, provided pro bono legal services for any person living with HIV requiring it for alleged complaints against discrimination.

Jamaica has supported its Network of People Living with HIV and AIDS since 2004 and by 2009 continued to assist the Jamaica Network of Seropositives to sustain its Board, Secretariat and 14 self support groups located throughout Jamaica. This Network is an important feature of the National HIV Related Discrimination Reporting and Redress System.

Preliminary work began in December 2009 towards an advocacy programme for high level leaders to deal with most at risk populations. Those leaders include entertainers, parliamentarians, and representatives from the business sector and faith based organisations.

During 2009, Jamaica has also made preliminary strides towards legislative support for policy guidelines. The Ministry of Labour and Social Security is leading the process to develop HIV regulations to ensure a foundation for enforcement of the National HIV/AIDS Workplace Policy. The HIV regulations are part of the proposed Occupational Safety and Health Act which has been mentioned in Parliament by the Minister of Labour during the steps to approve the National HIV/AIDS Workplace Policy during 2008 and 2009. Additionally the Ministry of Health is leading the process for amendment to the Public Health Order to treat HIV as a communicable disease only for reporting and surveillance purposes. This will help to decrease the misconceptions surrounding HIV as a contagious illness or one that has to be quarantined.

Efforts to build advocacy and awareness among high level leaders has also resulted in the Prime Minister and Representation from the Opposition signing commitment documents

for supporting ILO workplace principles on HIV/AIDS. During 2009, the Prime Minister of Jamaica at the annual leadership breakfast indicated that he will not support discrimination in schools which result in students being denied education. In 2008 at a similar event, the Prime Minister of Jamaica stated publicly that old laws such as the Quarantine Act, the Venereal Diseases Act and the Leprosy Act should be taken off the books.

Through the National AIDS Committee the Minister of Health led a high level delegation to the UNGASS Special Session in 2008. Accompanying the Minister were representatives from the Jamaica Manufacturers Association, the Ministry of Education, the Legal and Ethical Committee of the National AIDS Committee, the community of persons living with HIV and the National HIV/STI Programme.

**Prevention, Knowledge and Behaviour Change**

Behavioural and surveillance data confirm that the main risk factors fuelling the HIV epidemic are multiple sex partners, history of STIs, crack/cocaine use, and sex with sex workers. These factors have remained largely unchanged for the past two decades. In 2008 and 2009, the national HIV programme identified some key strategies to establish a comprehensive programme of prevention services. A critical component in these strategies was the use of innovative, culturally relevant and evidence-based interventions to reach target groups and to empower all sexually active men and women.

The main source of data on sexual behaviour and the impact of prevention efforts on Jamaica's population is the Knowledge, Attitudes, Behaviour and Practices (KABP) survey. The KABP survey is a national survey that is conducted every 3-4 years. The most recent, conducted in 2008, was a cross sectional, household based, survey of a randomly selected sample of 1800 persons island-wide. Respondents represented persons aged 15 – 49 years, with the younger group of 15 – 24 year old being over sampled to facilitate more robust analysis.

The 2008 KABP revealed revealed limited progress towards achieving national target for our Knowledge indicator, of 60% of males and females by 2011. The results showed 37% males and 42.3% women correctly identified both ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission. Analysis of individual items that comprise this composite indicator showed that between 2004 and 2008 there was a marginal decrease in the endorsement of appropriate methods of preventing HIV transmission, while there was a significant increase in the endorsement of the myth that people can protect themselves from being infected with HIV by avoiding being bit by mosquitoes. On the other hand, there was a significant decrease in the endorsement of the myth that people could avoid getting infected with HIV by not sharing food with PLHIV (Hope Enterprises Limited, 2008).

| | MALES | | FEMALES | |
|---|---|---|---|---|
| | YR 2004 (N=878) | YR 2008 (N=895) | YR 2004 (N=922) | YR 2008 (N=904) |
| Appropriate methods (prompted) (agreement) | | | | |
| One faithful partner | 91.9 | 85.0 | 89.8 | 83.0 |
| Condom use all the time | 93.8 | 89.3 | 93.1 | 91.9 |
| Abstinence | 84.1 | 77.8 | 85.7 | 81.9 |
| Inappropriate methods (prompted) (agreement) | | | | |
| Avoid mosquitoes and/or insect bites | 17.0 | 27.4*** | 12 | 22.3*** |
| Not sharing food with PWAIDS | 20.3 | 13.0*** | 13.7 | 8.0*** |
| Not touching someone with AIDS | 11.4 | 11.4 | 6.5 | 6.6 |

*=p<.05, ** = p<.005, ***=p<.000

**Table 3:** HIV/AIDS Specific Knowledge by Sex, 2008 KABP, Jamaica

When compared to 2004, significantly more males and females, irrespective of age, report having had more than 1 partner in the last 12 months. The percent of participants reporting multiple partners increased from 48% of men and 11.6% of women in 2004 to 61.5% of men and 16.8% of women in 2008. The survey also revealed that adolescents are initiating sex earlier. Among sexually active adolescents, the median age of first sex declined from 17.2 to 16.9 years (females) and increased marginally from 15.7 to 16.0 years for males in 2008. Also, transactional sex, defined as the exchange of gifts or money for sex, within the last year was common among just over a third (37%) of sexually active respondents. Worsening economic conditions partly explains these trends in behaviours. High levels of unemployment, persistent poverty, and a growing sex industry coupled with gender inequality contribute to the early age of sexual debut, age-mixing (sexual relationships between adolescent girls and older men), multiple partnerships and transactional sex.

Although behavioural surveillance of high risk groups such as commercial sex workers and men who have sex with men have been challenging, the NHP successfully carried out *Second Generation Behavioural Surveillance* activities with these groups between 2007 and 2009. Surveys

conducted among Sex Workers (2008) revealed that 26% of sex workers were able to correctly identify ways to prevent HIV infection. These surveys also revealed significant disparity in the uptake of testing in these two groups: only 31% of MSM (2007 MSM survey) had a HIV testing in the last 12 months, compared to 72% of SW (2008 SW survey). The reported condom use with last partner reflected a similar trend: 75% of MSM reported condom use with last male partner compared to 91% of sex workers who reported condom use at last intercourse with a regular client and 97% with new client. Condom use at last sex with main partners was lower (78%) among sex workers.

Intervention strategies to prevent the sexual transmission of HIV were in part formulated to address the gaps identified in these surveys. The main interventions that were implemented or scaled up in 2008 and 2009 included:

**Targeted Community Interventions (TCIs).** In 2009 a strategic decision was taken to scale up interventions implemented by the regional BCC teams in lower income, high prevalence communities. The number of TCIs was increased from one per year per parish to 5 per parish. Through TCIs, local communities were engaged in the design, implementation and evaluation of community-specific interventions with the aim of reducing social vulnerability to HIV infection.

**Figure 2:** Targeted Community Intervention worker entering a low income, high prevalence community.

**Targeted interventions among key populations at high risk.** Activities with key populations at high risk such as MSM, SWs, prison inmates, and crack/cocaine users were scaled up in 2008 and 2009. Interventions were delivered through community outreach as well as structured workshops. In all, over 2,000 MSM and 6,000 SWs were reached through a combination of outreach work and structured workshop interventions led primarily by the regional BCC teams, Jamaica AIDS Support for Life, and the Jamaica Red Cross. Outreach

activities included risk reduction counselling, screening for STIs, rapid testing for HIV, referral for treatment, and distribution of condoms. The series of empowerment workshops that was launched among MSM and SWs also emphasized personal development, risk reduction, social inclusion and reducing social vulnerability.

Over 1000 inmates were reached by the BCC team through their work in the prisons in 2008 and 2009, and the majority received HIV testing and provision of results and referral for treatment as appropriate. The National Council on Drug Abuse conducted outreach activities among over 145 homeless men and women, many of whom were active drug users.

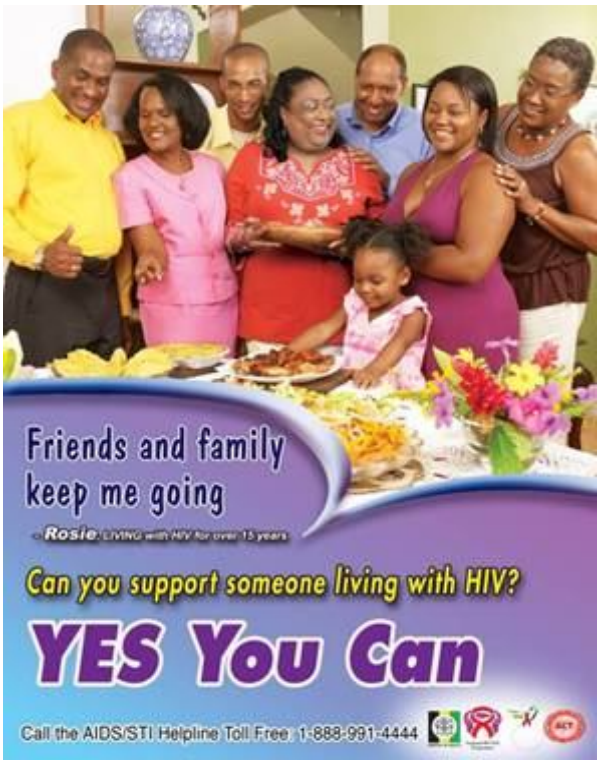
**Media campaigns:** Several major media campaigns were launched in 2008 and 2009. The campaigns were designed to position critical HIV issues on the public agenda, create a supportive environment for safer sexual practices, and to promote positive attitudes to reduce stigma and discrimination. The specific campaigns were the ***Yes You Can – Anti-Stigma Campaign*** and the ***Time to Talk- Abstinence Campaign*** (Parenting Tips) that are currently being aired on major television and radio stations. Another major campaign that was aired in 2008 and 2009 was the ***Pinch Leave an Inch and Roll (PLR) Campaign*** (condom use tips). Other campaigns that were developed and pre-tested in 2009 and are ready to be launched in 2010 include: ***VCT for Men, Multiple Partners among Men, and Women and Condom Use.*** See Figure 3 below for sample campaign material.

**Sports intervention**: 142 community-based coaches were trained to integrate HIV/STI information and risk reduction messages into their regular interactions with players. The strategy is intended to reach out-of-school youth, 16 -25 years old, by bringing prevention messages and skills to them in their own spaces and through person with whom they will have ongoing interactions.

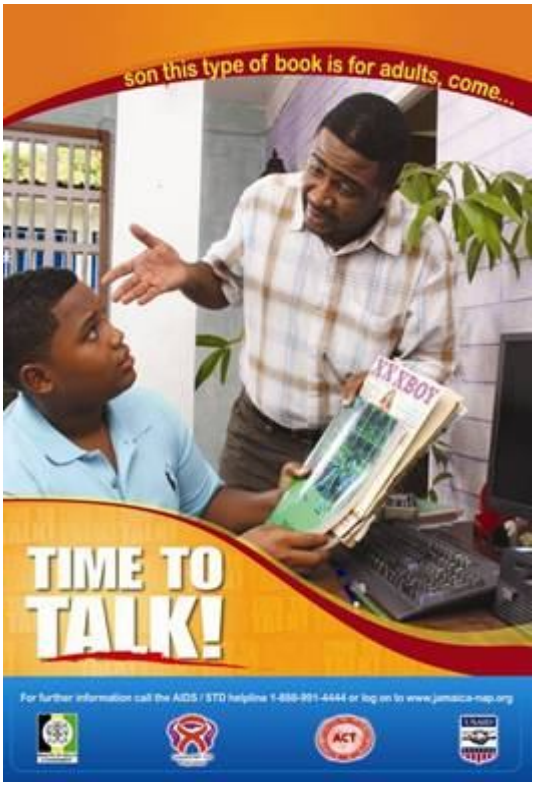
**Cultural vehicles:** The NHP partnered with a major talent search competition that broadcasted live to an estimated audience of 1.7M persons, largely youth and primarily young men. Contestants infused HIV lyrics into their performances, HIV media campaigns were aired during the broadcasts, and HIV facts included in the hosts' scripts. This intervention provided a unique opportunity to reach males 15-30 years, out–of-school youth and members of low income communities by tapping into the cultures of dance hall reggae, entertainment and music. The regions also rolled out a Party Intervention strategy that had considerable coverage of the target populations during the major party seasons.

The 'Bashy Bus' intervention also continued in 2008 and 2009. Public buses were identified as a site of sexual risk for many young persons and the 'Bashy Bus' intervention sought to redefine this space by using a bus as the setting for delivering SRH care and education to youth, both in and out-of-school. The peer educators use drama and music to deliver prevention messages focusing on HIV prevention, drug abuse, child abuse and other healthy lifestyle topics. They also offer HIV testing and referral for follow-up care.

**Figure 3:** New media campaigns in 2008 and 2009





**Establishment of new non-traditional condom outlets.** The regional BCC teams continued to work within communities to establish non-traditional condom outlets geared towards increasing the accessibility of condoms to sexually active youth, adults and vulnerable groups. Condom outlets have been established among taxi drivers, community advocates, and influential persons at night clubs. Over 600 non-traditional outlets have been established so far.

**Expansion of HIV testing:** Efforts to scale up HIV testing led to a highly successful programme that has been rolled out island wide, with the training of VCT counsellors, trainers, advanced and master trainers. This resulted in significant scale up of HIV testing. Provider initiated testing for all hospital admissions was also introduced in 2007 and scaled up in 2008 and 2009. Outreach testing was boosted by the procurement of mobile testing units and the introduction of the Oraquick rapid test, which uses oral fluid for HIV screening rather than blood, which was a deterrent for some persons. The output of the scaling up of HIV testing is confirmed by the significant increase in percent of respondents in the 2008 KABP reporting HIV testing in the last 12 months increasing from 14% men and 30% women in 2004 to 19% men and 47% women in 2008.

**Partnering with key line ministries:** Partnerships that were formed with non-government, faith-based organizations, private sector, other civil society groups as well as other government ministries have helped to ensure a multisectoral response to the HIV epidemic. These partnerships increased ownership of the national response by the various sectors. The partnership with the Ministry of Education has been particularly successful. Major policy achievement in this sector included the National Policy for the Management of HIV/AIDS in Schools revised (2008) and a Workplace Policy for the Education Sector developed (2009). At the end of the 2008/2009 school year, The MoE had distributed over 997 HFLE curriculum charts, pamphlets, CDs, DVDS and other IEC materials. In addition, the roll out of the HFLE curriculum, which began in 30 schools in 2006, had been implemented in 447 schools as of June 2009.

The period 2008 and 2009 was also marked by significant scale up and major progress towards institutionalizing the prevention program in the Ministry of National Security. The Sector Policy created using the consultative approach since 2005, was edited during 2009 with a proviso section on fitness for work as it relates to armed and police forces under the principle of *no screening for exclusion from work.*

Table 4 lists the sub-grants that were awarded for the period 2008 to 2010 under Round 7 of the Global Fund grant.

| MOU BUDGET (US$) | SUB-RECIPIENT |
|---|---|
| 114,667.70 | 3 D's Projects |
| 126,037.83 | Combined Disabilities Association |
| 103,530.97 | Jamaica Youth Advocacy Network |
| 78,438.57 | Ministry of Labour and Social Security |
| 29,884.14 | Ministry of Tourism |
| 37,411.53 | PRIDE in Action |
| 64,787.62 | YPM Youth Centre |
| 30,175.92 | Ministry of National Security |
| 48,323.65 | JABCHA |
| 109,908.06 | JEF/JABCHA |
| 17,303.93 | PANOS Caribbean Institute |
| 218,199.04 | Jamaican Network of Seropositives |
| 79,702.60 | UWI Health Centre |
| 63,476.37 | CHARES |
| 452,150.34 | Jamaica AIDS Support for Life |
| 664,081.69 | National AIDS Committee |
| 252,860.41 | ERTU/CHART |
| 124,095.17 | Hope Worldwide Jamaica |
| 784,230.10 | Ministry of Education |
| 265,961.78 | JAPPAIDS |
| 72,828.73 | National Council on Drug Abuse |
| 225,104.05 | Jamaica Red Cross |
| 266,907.71 | Children First Agency |
| 668,741.20 | South East Regional Health Authority |
| 385,772.56 | Southern Regional Health Authority |
| 267,372.36 | North East Regional Health Authority |
| 449,874.64 | Western Regional Health Authority |
| US$6,001,828.68 | TOTAL |

Table 4: NHP Sub-recipients, 2008 - 2010

**Greater Involvement of People Living with HIV (GIPA):** A desk to support the Greater Involvement of People Living with HIV and AIDS (GIPA) and their integration into the national HIV/AIDS response was established during December 2008. A person living with HIV was hired as a GIPA Coordinator to manage the process under the Enabling Environment and Human Rights Component. The sub-project operated on four main levels:

1. To expand the participation of PLHIV in existing interventions on request such as workshops in the workplace programme by delivering sessions on Basic HIV/AIDS Facts, GIPA and the National HIV Related Discrimination System (NHDRRS);

2. To participate on special committees and panels representing the PLHIV community on request;
3. To coordinate the selection, sensitisation and training of 20 PLHIV per year for their greater involvement in risk reduction and HIV-related discrimination reduction interventions;
4. To assist the Jamaican Network of Seropositives (JN+) and the National HIV Related Discrimination Reporting and Redress System (NHDRRS) through active participation in selected interventions.

By the end of 2009, the PLHIV community was represented on interview panels for the selection of consultants and officers; and on special committees such as the Interim Investigation Team for the National HIV-Related Discrimination Reporting and Redress System. The GIPA coordinator was an active participant in numerous sensitization and training sessions for the private and public sectors and for faith-based organisations. The coordinator also coordinated the selection of a cadre of PLHIV for a needs assessment study to be followed by sensitization and training for their greater involvement in the national HIV/AIDS response.

**Treatment, Care and Support**

It is estimated that of the 27,000 PLHIV, at least half of HIV infected persons are unaware of their status, and approximately 14,000 persons have advanced HIV and are in need of treatment. The public access to treatment program was established in September 2004 and in 2006 treatment guidelines were revised to include new options for second line therapy and recommendations for starting ARV treatment at Cd4 count <350 (Advanced HIV). This need for identifying persons at an earlier stage of disease and the role of positive prevention reinforced the urgency of increasing access to HIV testing.

Several strategies were employed to increase access to HIV testing: introduction of HIV rapid testing, decentralization of HIV testing from 1 main lab to 4 regional labs, increase cadre of VCT counsellors (more than 2,000 counsellors in 2009), engagement of the private sector, implementation of provider initiated testing and counselling, and opt-out testing for persons most at risk including pregnant women, STI clinic attendees and hospital admissions. HIV testing increased from 39% ANC attendees in 2003 to 95% in 2008 and in 2008, 223,121 HIV tests were done islandwide.

In 2009, 23 treatment sites were providing multidisciplinary care in Jamaica and laboratory capacity was improved to provide tests such as CD4 count and viral loads. Based on programme monitoring, 6,895 persons (6,459 adults and 436 children) with advanced HIV (49% of persons with advanced HIV) were started on treatment by the end of December 2009. The decrease in estimated ARV coverage is mainly due to the much higher estimate of number of persons in need of treatment based on the revised UNAIDS Spectrum and EPP software. The 2009 estimates process benefited from an increased availability of national and international data thereby improving the assumtions of the model. The outputs of the software indicate that as many as 14,000 persons are in need of treatment for HIV in Jamaica. Revised targets and treatment goals will be addressed in upcoming Strategic Planning sessions for the period 2010 to 2012.

The impact of the treatment program is reflected in surveillance data, which shows a decrease in the number of AIDS deaths from 665 in 2004 to 401 in 2008. In addition, 12 month survival after initiation of ART is 91% when ARV databases at 5 treatment sites (urban and rural) were examined.

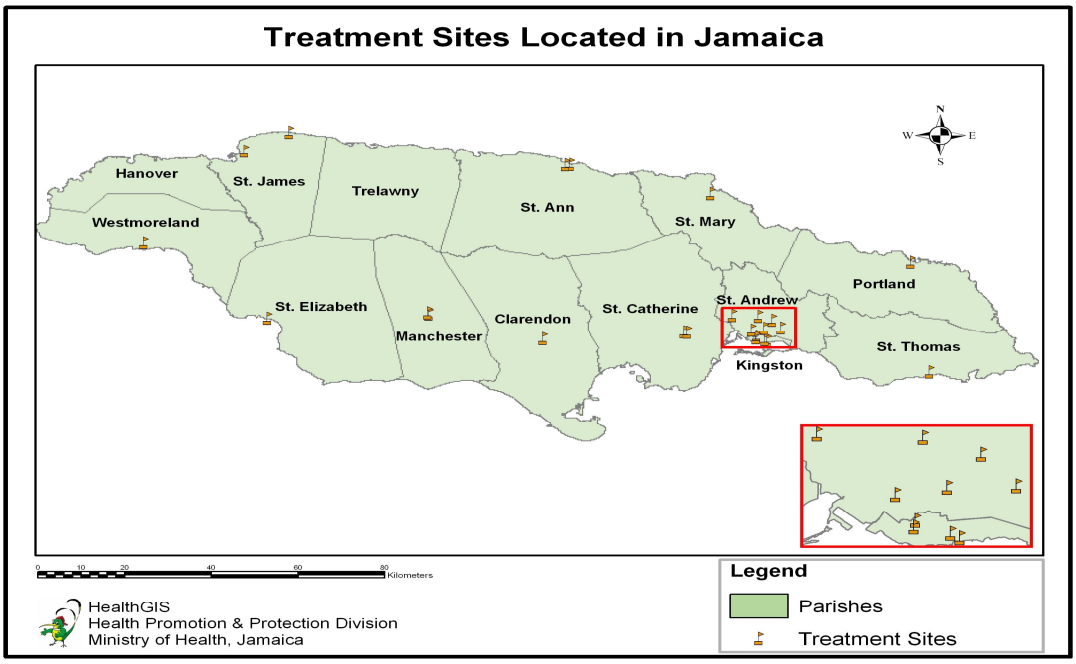



**Figure 4**: Map of Jamaica showing the locations of public HIV treatment sites in the country

Jamaica's pMTCT program involves opt-out testing for pregnant women with referral of HIV positive pregnant women to high risk antenatal clinics for multidisciplinary care and HAART for pMTCT. Rapid testing is also available on some labour wards for women with unknown HIV status. This has resulted in provision of ARVs for 83% of pregnant women delivering in the public sector and at least 95% of HIV exposed infants in 2008/2009. Although limited data is available from the private sector, national surveys repeatedly suggest that pMTCT coverage is also high in the private sector. For example, the 2005 MICS conducted by UNICEF confirmed that 90% of women who gave birth in the 2 years preceding the survey were offered HIV testing and counselling during their antenatal visit. Similarly, the 2008 national KABP revealed that more than 90% of women who were pregnant in the 2 years preceding the survey received HIV testing counselling and their results (Hope enterprises, 2008). A review of PCR testing results for HIV exposed infants suggest that MTCT in 2009 may be <5%.

Other activities undertaken to strengthen the treatment, care and support of PLHIV from 2008 to 2009 include:

- **Strengthening of the adherence program** by revision of adherence guidelines and continued support for adherence counsellors islandwide.
- **Improved laboratory capacity** to identify TB infections through the procurement and installation of the BD bactec liquid culture machine.

**Figure 5:** Public sector laboratory

- **Implementation of an electronic patient register** at all treatment sites to facilitate monitoring persons receiving ARVs.
- **Baseline survey** of PLHIV at treatment sites as part of a protocol to assess adherence.
- **Continued partnership** with 74 private physicians to enable the treatment of PLWHA in the private sector.
- **Capacity Building** by conducting several training workshops annually for all categories of health care workers (including Pharmacists, Doctors, Nurses, Social workers Contact Investigators, adherence counsellors etc.) in clinical management of HIV/AIDS
- Introduction of **Dried blood spot technology** for early infant diagnosis using DNA PCR
- **Scaling up of HIV testing** including provider initiated testing and counselling (PITC) implementation at major hospitals.

**Challenges in Treatment Care and Support**

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

- Strategies must be developed for case identification including increased access to testing for high risk populations as 50% of persons who are HIV positive are

unaware of their status. In addition, HIV surveillance data suggests that despite expansion of HIV testing, many persons present to care in advanced stage of HIV infection.

- Adherence to medication is suboptimal. A 2009 baseline survey of PLHIV accessing care in the public sector showed that 77%% of persons had $\geq$ 95% adherence to ARV based on self-report. A strategy to address adherence has been developed and is being evaluated.
- With expansion of treatment programmes the emergence of HIV drug resistance (HIVDR) is of increasing concern. Collaborations with other countries have increased availability of HIVDR testing and a local laboratory is beginning to undertake drug resistance testing. An HIV genetic diversity study in Jamaica is also providing insight into the level of HIVDR.
- In 2009, >80% of persons with suspected TB were tested for HIV but data on extent of screening of persons with HIV for TB is unknown.
- Greater partnership with the private sector is required to increase access to treatment.
- ARV coverage for HIV infected pregnant women is sub-optimal as nearly 20% of women and 5% of HIV exposed infants continue to escape the net of the current pMTCT program. This is attributed to late presentation to antenatal care and failure to disclose HIV status when presenting to the health system. HIV infected mothers sometimes refuse replacement feeds because of a fear that failure to breastfeed may be admission of one's status and HIV exposed infants are sometimes lost to follow up. Education about the availability of services for pMTCT and strengthening of the roles of members of the multidisciplinary team involved in the pmTCT programme (social workers, psychologists, nutritionists and adherence counsellors) continue to be priorities to decrease the gap in coverage.

**Impact Alleviation**

With the introduction of public access to antiretroviral treatment (ARV), there has been a significant decline in AIDS cases and AIDS deaths between 2004 and 2008. In addition, mother to child transmission of HIV (MTCT) has declined from 25% before ARV introduction to <5% in 2008. To bolster the gains made in treatment, several programmes were implemented to enhance the care and support available to those who are infected with or affected by HIV.

A Situational Analysis of OVC in Jamaica (Carpenter, 2008) found that the majority of parents and caregivers of OVCs were experiencing high levels of poverty. At the time of the analysis, 78.2% of the sample perceived little or no help was forthcoming from institutions. However, this perception was largely due to "both reluctance on the part of caregivers to seek out these services and a lack of responsiveness on the part of those agencies that were

approached. This reluctance to seek out additional assistance was due mainly to the fear of the community discovering their HIV status or their children's."

A number of initiatives have been put in place to improve the care and support systems for those who are infected with or affected by HIV:

The National AIDS Committee (NAC), through the Parish AIDS Associations, (PAA) has contributed significantly to the welfare of children who are infected with or affected by HIV and AIDS. In 2009, **back to school assistance** was provided through the Parish AIDS Associations. Social Workers and adherence counsellors attached to health facilities were able to identify families who were in need and referred them to the PAA to receive support in the form of: i) payment of school fees, ii) purchase of school books, and iii) purchase of school uniforms. This assistance is ongoing and has been well received by the recipients.

In 2009 the NAC has also received US$100,000/year for a five (5) year period from the NHP to develop an **Income Generating Grant Project** for PLHIV. This project aims to establish a reliable source of income and improved standard of living by supporting income generating activities among PLHIV. Through this project, the NAC provides grants to assist PLHIV in setting up or expanding income generating projects/activities or to seek training or certification of skills.

The NAC has also provided a number of PLHIV the opportunity to gain technical and vocational training and certification as well as basic literacy and numeracy skills, through partnerships with the national **vocational training institute** (Human Employment and Resource Training (HEART) Trust) and the Jamaican Foundation for Lifelong Learning (JFFL) Programme. Persons are referred to these programmes through their local PAA chapter or through social work staff in the treatment sites.

**Figure 6:** HEART/NTA skills training booth at WAD outreach testing event

The NHP, in consultation with stakeholders, designed a comprehensive **Positive Prevention strategy** for the treatment, care and support for persons living with or affected by HIV. The Positive Prevention strategy examines issues of adherence and psychosocial support. This strategy also provides a standardized curriculum for support groups, which provides guidance on how to address critical issues faced by persons as they adjust to living with HIV, and also risk reduction strategies to prevent new infections. A PLHIV Liaison Officer was hired for each region to implement the components of this strategy. The PLHIV Liaison officers work alongside social workers and adherence counsellors to conduct needs assessments, identify gaps in the care and support provided to PLHIV and their families, and provide referrals or direct assistance as appropriate.

A significant activity at the NHP was the establishment of a desk during December 2008 to support **the Greater Involvement of People Living with HIV and AIDS (GIPA)** and their integration into the national HIV/AIDS response. A person living with HIV was hired as a GIPA Coordinator to manage the process under the Enabling Environment and Human Rights Component. The sub-project operated on four main levels:

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### National Composite Policy Index - Trend Analysis

This is a trend analysis of the National Composite Policy Index conducted bi-annually from 2003 to 2009. Several issues were noted in implementation of the NCPI:

1. The objective of the survey is not clear. Is it purely seeking subjective data i.e. information provided from the perspective of the interviewed stakeholders?

2. Definitions of terminologies used in survey were not provided and left partly to the discretion of the interviewer

3. No guidelines on data analysis were provided.

4. There were no specific instructions on how to handle discrepancies between responses and desk review.

In addition, trend analyses were problematic as the instrument changed between reporting periods and many programme ratings were initially high leaving very little room for change.

The following is a summary analysis of the consistent areas from 2003 to 2009 using NCPI summary template as a guide. Two scales were used to rate the questions over the duration of the questionnaire administration.

***a) 1 to 10 with 1 being low/very poor and 10 being high/excellent***
***b) 1 to 5 with 1 being low and 10 being high***

Unless otherwise stated, ratings were based on a scale of 1 to 10. Part A represents the findings of the survey of government officials while Part B represents the survey of representatives from civil society organizations, bilateral agencies and UN organizations.

## PART A (Government Officials)

### I. Strategic Planning

Efforts in strategic planning have remained consistent since 2005 when the multi-sectoral strategy to combat HIV/AIDS was developed and the country integrated HIV and AIDS into its general development plans. Action frameworks for addressing the nation's uniformed services were put in place. Strategic planning would appear to be strong in Jamaica's response to HIV/AIDS with rating for strategic planning efforts in the HIV and AIDS programmes moving from 7 in 2003, 8 in 2005 and 2007 to 9 in 2009.

### II. Political Support

Heads of government and other high officials have been speaking out positively on an ongoing basis about AIDS efforts in Jamaica since 2005. Also, a national multi-sectoral coordinating body (NAC) exists that carries out its mandate to promote interaction and collaboration between PLWHA, the private sector and civil society towards the goal of HIV strategic and programmatic implementation. Despite this, the perception of the political framework towards HIV has not changed. With outdated laws that present obstacles for adolescents, SW, MSM and prison inmates, prevention and treatment

efforts to these populations are not able to be fully maximized. The existing political framework has also been implicated in contributing to the stigma and discrimination faced by MSM. Several efforts have been made in this area however, through the review of laws that stand as obstacles to prevention, but to date no major achievements are noted in this aspect of political support. An incremental increase was noted in the overall ratings for political support for HIV/AIDS programmes from 7 in 2005 to 8 in 2007; however reduced to 7 in 2009.

**III. Prevention**

Prevention efforts since 2003 have been strategic in providing the general public and most at risk populations with IEC and prevention commodities for HIV/AIDS. Since 2005, the programme began incorporating specific strategies for most at risk and vulnerable populations in a variety of settings. It is vigilant to the related reproductive and sexual health education needs of adolescents and young people. Findings from the NCPI indicate that perceived weaknesses in the prevention efforts are directly related to the barriers encountered through the political arena where policies, regulations and law impede their full reach to MARPs (SW, MSM, and Adolescent). Notwithstanding these challenges, ratings for policy efforts in support of prevention have seen marked incremental increases from 2003 to 2007; receiving ratings of 4 in 2003, 6 in 2005, 7 in 2007. However, 2009 saw a reduction in rating to 6.

**IV. Treatment Care and Support**

The treatment care and support arm of the country's response has improved steadily since 2003. The ratings provided for efforts in the treatment, care and support area moved from 6 in 2003 to 8 in 2005, with 2007 and 2009 seeing ratings of 9. Several adjunct treatment, care and support interventions were implemented in 2007 and 2009. These include TB screening for HIV-infected persons and TB infection control in HIV treatment and care facilities. The scale-up of testing and the number of persons on ARV, are noted as key achievements in 2009 adding further evidence of the marked improvements in this area. Work with OVCs, however, has fallen in ratings in 2009. Although there are policies in place to address the additional HIV and AIDS related needs of OVCs, and gradual improvement in ratings were noted from 2003 to 2007, it reduced in 2009 to 7; the rating allocated in 2005

**V. Monitoring and Evaluation**

Monitoring and Evaluation has seen steady increases for the duration of the NCPI surveys. With ratings of 6 and 7 in 2003 and 2005 respectively, it increased to 9 in 2007 and remained there for 2009. Jamaica has one National M&E plan, with a budget. It has a functional M&E unit with a working group that meets regularly to coordinate the M&E activities. Reports are published at least once per year and are consistent in regards to the extent to which strategic information/M&E data is used in planning and implementation. This was rated as 8 (0.8) in 2005, 2007 and 2009 had ratings of 4 (out of

5) (0.8). Other significant achievements in 2009 are the publication of the M&E Plan and Operations Manual.

## PART B (civil society organizations, bilateral agencies, and UN organizations)

### I. Human Rights

Ratings for efforts in implementing policies, laws and regulations for Human Rights have remained relatively lower than other areas over the period. Although in 2005 interviewees responded in the affirmative to having laws and regulations that protect persons living with HIV/AIDS against discrimination, and no to the presence of laws and regulations that present obstacles to effective HIV prevention, their responses in 2007 and 2009 were reversed. On the other hand, respondents maintained that there were laws and regulations in place to ensure equal access of services for men, women and most at risk population, that research involving human subjects are ethically reviewed and approved and that HIV screening for general employment purposes are prohibited. Fluctuations in ratings were noted in regards to policies, laws and regulations in place to promote and protect human rights with a rating of 6 given in 2009, as compared to 5 in 2005. An incremental increase was seen in regards to efforts to enforce the existing policies, law and regulation from 3 to 5 during the period. See Appendix D for a breakdown of responses in key areas from NCPI 2003 – 2009

### II. Civil Society Participation

Whereas in 2005 the extent to which civil society representatives have been involved in planning and budgeting processes for NSP was 7, it saw a decline in 2007 and 2009. This decline was also noted as it related to the extent to which civil society has made significant contributions to strengthening the political commitment of top leaders. Services provided by civil society being included in the National Strategic Plan and reports were rated at 7 (0.7) for 2007, it was rated 3 out of 5 (0.6) and an average of (0.7) for 2009 (in 2009 strategic planning and reports were rated separately) reflecting some fluctuation. The overall ratings of efforts to increase civil society participation were consistent for the years 2005 and 2007 but fell in 2009. See Appendix D for a breakdown of responses in key areas from NCPI 2003 – 2009.

### III. Prevention

The prevention activities are being implemented in support of the HIV prevention strategy: This was a consistent response since 2005 and efforts in the implementation of the programme increased from a rating of 6 in 2003, 7 in 2005 to 8 in 2009. See Appendix D for a breakdown of responses in key areas from NCPI 2003 – 2009

### IV. Treatment, Care and Support

Activities under treatment, care and support services are being implemented and the country has a policy and a strategy to address the additional needs of OVC. Ratings for

efforts in care and treatment moved from 6 in 2003, to 9 in 2005, and then ratings trended downward to 8 in 2007 and 2009. Similarly with the effort to meet the needs of OVC, it showed an increased rating from 2003 to 2005 and was consistent into 2007 and 2009. See Appendix D for a breakdown of responses in key areas from NCPI 2003 – 2009.

# V. Best practices

### "Hold on, Hold off, Abstain, Get the Skills" School-based Intervention

The "Hold on, Hold off, Abstain, get the skills" intervention was conducted at an inner-city high school in the Kingston area. This particular school was chosen because of its location in a high HIV prevalence, inner city community and the reported high level of sexual activity, marijuana use, poor reading skills and behaviour problems among its students. The Intervention was site specific and sought to address these issues.

The first step in developing the intervention was a stakeholder meeting between the intervention team and stakeholders in this school. This meeting was followed by the collection of baseline data (survey) to further inform the teams' way forward in the school. A team comprised of young people delivered the intervention during classroom sessions, at lunch and during after-school activities.

The classroom sessions targeted students in the 7th and 9th grades. These grades were selected to enhance sustainability and to allow experienced students to assist the younger ones. Class sessions were designed in a way that allowed the students to work in groups, share their opinions, and practice giving each other appropriate and factual advice. The topics covered in the classroom sessions included: self esteem, peers and their influence, emotional changes and urges, gender and gender role expectations, relationships, HIV transmission, and basic facts about STIs. A variety of tools were used to deliver the sessions: drama, group discussions, group work, games, and presentations. Over 400 students were reached during the classroom sessions.

The lunch time interactions consisted of one-on-one and group risk reduction conversations with the students. Students were targeted in classrooms, under trees in the school yard, and other popular lunchtime hang out spots. These sessions provided an opportunity to have unstructured conversations with students and to personalize the risk reduction messages.

The after-school arm of the intervention was delivered through a summer camp format (day programme). A variety of students were chosen to participate in the summer session. Participants included outstanding students, others with identified behavioural issues, and students who showed the need for additional information and risk reduction interaction.

Another important component of this intervention was the parenting sessions. Parents were reached through parenting workshops that sought to provide them with the skills to discuss sexual and reproductive health issues with their children.

The team learnt a number of important lessons from this intervention.

1. Messages reaching young people should be clear and practical.

2. The physical context, meaning the community the students are from and where the school is located, must be taken into consideration when designing interventions that target students.
3. Students must be able to access SRH services. Given the high level of sexual activity that the students admit to, it is paramount that they have access to condoms and receive appropriate condom use skills.
4. Students need to be given real opportunities to participate in the design and actual roll out of interventions targeting them. Students benefit from participating in the process and are more accepting of the final intervention.
5. Collaborating with other sectors is important to effectively address the social issues that affect students and their families. Important partners included a dispute resolution group and the National Council on Drug Abuse, amongst others.

**National HIV/STI Programme, Monitoring and Evaluation Unit**

The NHP is an expansion of the STI control program of the MOH. The program was established in 1988 in response to the emerging HIV epidemic in Jamaica. From the outset, the NHP implemented a surveillance system including collection of data on persons with HIV and AIDS in 1982, and conducting Sentinel Surveillance of ANC and STI clinics starting in 1989. The early monitoring system also included the Knowledge, Attitudes, Beliefs and Practices population based Survey, which was first completed in 1988.

Despite these very important data gathering activities, the M&E system was largely informal. There was no central database, coordinating unit or data management unit in the National Programme to coordinate reporting and process data related to the HIV response. Reports were inconsistent and varied in the data captured limiting data utilization. Further, stakeholders did not have a clear understanding of the relevance of their reports as there was limited knowledge of the programme indicators and few mechanisms for data dissemination. In addition, the NHP was overwhelmed by reporting requirements of regional, international and donor agencies. Reporting on more than 100 indicators was the norm.

Some of the key actions that were taken to strengthen the M&E system include:

- Formation of functional M&E unit in 2004 – processing unit for all HIV/STI data
- Increasing M&E unit resources including hiring M&E Officer, Biostatistician and Data entry staff
- Harmonization of indicators with identification of 30 core indicators (versus >100 indicators previously)
- Development of an M&E plan and operations manual with clear roles and responsibilities, data flow maps and indicator definitions
- Standardization of reporting tools
- Development of a M&E database for easy processing of M&E reports

- Capacity building of all stakeholder in M&E through training workshops and provision and use of technical assistance
- Implementation of strategies for regular dissemination of information garnered from the M&E system
- Solicitation of Technical Assistance
  - Supported by MEASURE, UNAIDS, GAMET, PAHO
- MERG revitalized, TOR drafted, and network of M&E personnel established
- M&E Plan for the 2007-2012 NSP finalized
- Monitoring responsibilities integrated into Terms of Reference
- Shift from paper based to computerized data management
- Developed tracking system for stakeholder reporting

These actions have contributed to the increased availability of high quality data with greater dissemination and utilization for strategic planning.

**JN+ Mobilisation of PLHIV in Prevention with Positives, 2006 – 2009**

The increased availability of ARV treatment in Jamaica has resulted in greater numbers of people with HIV maintaining or returning to their normal lifestyles. For most, this includes the natural expression of human sexuality. As a result, this has put them and their partners at greater risk of contracting sexually transmitted infections. In order to address this issue, JN+ received support through the Prevention and Treatment Advocacy Project (PTAP) funded through the Latin American and Caribbean Council of AIDS Service Organisations (LACCASO) and managed by Jamaica AIDS Support for Life (JASL).

The primary objectives of this project were:

- Training a cadre of JN+ members to disseminate Prevention with Positives information in self support groups. and document the sessions for M&E purposes
- Build awareness among JN+ members as to the risks of unprotected sex
- Empower JN+ members to choose safer sexual practices

The outputs/outcomes included:

- A comprehensive training of trainers manual was developed.
- 5 colourful low-literacy modules for use in self support groups were produced
- A cadre of over 20 PLHIV were trained to disseminate Positive Prevention information among peers. This included both training in communication skills, positive prevention knowledge, and proper reporting and documentation procedures.
- More than 60 self support group meetings were conducted focusing on Positive Prevention education

- Over 200 PLHIV were educated about Positive Prevention and support in adopting healthier behaviours

The project has provided the following lessons:

- Positive Prevention programmes must employ a holistic approach that takes into consideration the inter-relationship between diverse issues such as the psychological impact of a positive test result, disclosure, safer sex negotiation, healthy lifestyles, and dealing with opportunistic infections, treatment, and adherence.
- Positive Prevention must recognise and strike a balance between the rights and responsibilities of everyone regardless of HIV status.
- Peer educators in Positive Prevention need appropriate coaching, mentorship and monitoring to ensure effective dissemination of information.
- Positive Prevention messages must be provided in a user-friendly format and be reinforced through repeated exposure and peer support.

**Improved Treatment, Care & Support Services through Mentorship and Preceptorship**

Clinical mentoring and preceptorship for clinicians is another successful training strategy to improve the care of PLHIV. The ERTU-CHART began offering a two day preceptorship at the Comprehensive Health Centre, a major centre for STI treatment in Jamaica. The preceptorship involved one or two clinicians working alongside the clinical mentor as he/she saw PLHIV with appointments and walk-ins. They were able to observe/participate in the wholistic and multidisciplinary care for different scenarios of the clients. As the clinic has a high caseload they were exposed to many scenarios in a short time. This exposure to a treatment facility with a high case load, increases the experience of clinicians who are new to HIV treatment sites. In addition, preceptorships have been extended to on-site training so the clinicians do not have to leave their posts.

Applying the principles of adult learning, the preceptees/mentees are able to identify and fill gaps in the provision of care to PLHIV. In addition, the mentor and mentee establish a long term relationship with technical and advocacy support by the mentor as required.

While this methodology does not produce great numbers for training indicators, it improves quality of care indicators.

## *VI. Major challenges and remedial actions*

Major challenges reported in 2007 and their remedial actions during this reporting period are summarized below.

**Data capturing:** Data collection tools continue to be refined and modified to improve reliability and accuracy of data. This includes modification of paper-based stakeholder reporting, expansion of the M&E database to capture additional reports and generate new reports, and modification of databases such as the electronic ARV database and rapid test database to capture new variables. The ARV database was also implemented at 3 new treatment sites. Since the last UNGASS reporting period, an M&E plan has been printed and disseminated to stakeholders and an M&E operations manual has been developed to detail all the core indicators of the Jamaica national response. These manuals also address issues related to data flow, data quality, definitions of indicators and data use. Training workshops were conducted island wide for all stakeholders to implement the M&E plan thereby increasing capacity to conduct M&E including data analysis. Operational research, including a recent MSM and SW survey, gives insight to the behaviours that perpetuate HIV transmission and confirmed the estimated high HIV prevalence in the MARPs. M&E continues to play a central role in national and stakeholder meetings. Such meetings, including meetings of the MERG and the NHP website have been ideal forums for data dissemination. Despite these improvements in the M&E system, timeliness of reporting and implementation of electronic data collection tools have been sub-optimal. In addition, the failure to meet some outcome indicator targets reinforces the need to evaluate interventions before replication in various sectors.

**Access to High Risk populations:** Stigma and discrimination (S&D) reduction are critical factors for increasing access to MARPs. Between 2008 and 2009**,** the National HIV Related Discrimination Reporting & Redress System was strengthened and a Multisectoral Advisory Group was formed. This provided the forum for tracking and addressing cases of reported discrimination. Other strategies to address S&D include advocacy for non-discrimination in the insurance sector and legislation to protect human rights, greater involvement of PLHIV (GIPA) in the national response including formation of a GIPA unit, sensitization of persons in various sectors, development of HIV policies in various sectors including all ministries of government and targeted large enterprises, and advocacy among high level leadership. On December 1, 2009, a new anti-stigma campaign was launched with the theme "Yes, I can support someone living with HIV".

However, sodomy continues to be illegal and persistent fears of being subject to discrimination continue to hamper the implementation of services for some persons at risk.

These issues also limit the understanding of the epidemic in some MARPs as sampling methods rely on snowballing and excludes some subgroups among MARPs.

**Need to Expand Prevention Programs.** This was partly achieved through greater use of targeted interventions including sites where MARPs frequent, development and implementation of a positive prevention strategy, continued implementation of HFLE in schools, mass media campaigns/material development (focusing on condom use, HIV testing, stigma reduction and abstinence) and sectoral policy and programme development. Nevertheless, the persistence of high risk behaviours and high pockets of HIV prevalence emphasize the need for further expansion of prevention programmes and determination of the impact of the services already implemented.

**Sustainability of the national response to HIV.** The national HIV program is mainly funded by government of Jamaica, a World Bank Loan and a Global Fund Grant (round 7). This was achieved through costing of the new national strategic plan, documentation of the human resource needs for sustainability of the national response, negotiation with the ministry of health and other relevant ministries for absorption of essential posts, negotiation with the World Bank for additional funds, and successful submission of a proposal to the Global Fund for Round 7 funding. In addition, for the first time the MOH now has a recurrent budget for the HIV Programme.

The HIV epidemic continues to evolve and despite expansion of programmes, many at risk persons do not access HIV related services. Many of the challenges from the previous reporting period have persisted and reinforces the need for new strategies and an in-depth understanding of the HIV epidemic. In order to achieve universal access and halt and reverse the epidemic by 2015, persons must know their HIV status and adapt safe sexual behaviour, persons in need of treatment must be identified, and the policy environment must facilitate access to services by all persons including those most at risk. The current gaps and challenges are reflected by the principles that guide the priority strategies of 2010/2011 which include:

- Expansion of prevention programmes especially among MARPs including intense risk reduction messages, peer counsellors and access to testing.
- Strengthening of positive prevention programmes.
- Scale up of HIV Testing, particularly of most at risk populations (MARPS) and Hospital Admissions, in order to identify persons in need of treatment and delay progression to AIDS and AIDS deaths. The implementation of confirmatory rapid test algorithm and PITC will facilitate further scaling up of HIV testing.
- Scale up of HIV Treatment, targeting at least 900 persons with advanced HIV/ year by increasing access to HIV testing for MARPs
- Improved diagnosis and management of STIs using point of care diagnostic tests

- Continued capacity building for stakeholders on M&E through widespread training and use of technical assistance.
- Increased dissemination and utilization of data (in particular existing data sets) for programme planning and understanding the HIV epidemic
- Implementation of electronic information systems, in particular web-based HIV/AIDS Tracking System, using hands on training of first line users
- Reduce S&D through: further development of the system for reporting and redress of discrimination, advocacy among high level leadership, policy development in various sectors, and extensive mass media campaigns.
- Increased operational research, including implementation of a research agenda to answer key questions for programme management

# VII. Support from the country's development partners

The development partners continue to contribute to the multi-sectoral response to HIV in Jamaica by participation in the national strategic planning process, identification of programmatic priorities, conveying information about the HIV response at the regional and international level and identification of standard practices. Partnerships with development partners have increased access to financial and technical resources. However, despite development of one strategic plan, conflicting priorities sometimes result in the diversion of resources from agreed programmatic priorities to the priorities of development partners as each organization attempts to accomplish their mandate. Although greater harmonization of indicators has been realized, the various reporting requirements of each partner continue to be a strain for stakeholders, which already have limited human resources. This detracts from implementation of activities.

The development partners may assist with achievement of UNGASS targets by:

- Provision of financial and technical resources when required to strengthen interventions and data collection efforts.
- Fostering growth of technical capacity of stakeholders.
- Strengthening relationships and communication with key stakeholders in the national response.
- Establishing selves as ambassadors and facilitators of the One National Strategic Plan.
- Further harmonization of procurement and reporting requirements e.g. UNGASS versus Universal Access Report.

# VIII. Monitoring and evaluation environment

## Overview

The Jamaica Monitoring and Evaluation (M&E) system consists of various inter-related components (see Figure 7) which provide data from special surveys and program monitoring. These data inform specific indicators, detailed in the national M&E plan, that guide programme managers and various stakeholders on the progress and impact of interventions being conducted. The information is presented through various publications and reports on a regular basis. The M&E system benefits every contributor by providing information on various levels to improve programmes and policies around HIV/AIDS. During this reporting period the M&E system was strengthened by the development and printing of the M&E operations manual which will serve as a reference tool detailing the various data sources for indicators.

Data sources for various indicators include routine data sources, which collect data on a continuous basis, and non-routine data sources that are collected on a periodic basis, (usually annually or less frequently). Some elements of the M&E system are well established and have provided important output, outcome and impact data to the NHP from as far back as 1986. Examples of routine data sources include:

**Stakeholder reports:** Many output indicators (e.g. numbers reached by prevention activities, number of CD4 counts done, number of PCR tests done on HIV exposed infants) are collated from monthly stakeholder reports, which are processed by the M&E unit. Stakeholder reports include monthly reports from NGOs, FBOs, line ministries, regional health authorities, regional laboratories and treatment sites.

**HIV/AIDS Tracking System (HATS):** This is an ongoing HIV surveillance system that is based on confidential case reporting by health care workers in addition to active surveillance of hospitals, hospices, death registries, among others, by a surveillance officer. Case reports include demographic information, mode of transmission, risk factors, and stage of infection.

**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).

**The Jamaican Health Information System:** This system consists of a few stand-alone databases which provide information to the M&E system. In particular, the monthly clinical summary report supplies aggregate data on important health indicators from over 300 health centers islandwide.

**HIV-related Discrimination, Reporting and Redress System:** This system is guided by a multisectoral Reporting and Redress Advisory Group, which includes representatives from the NHP, UNAIDS, Human Rights organizations, Ministry of Labour & Social Security, PLWHIV, NHP, among others. Representatives are M&E personnel, PLWHIV, Advocates, Policy Coordinators, and lawyers. A database and data collection tool has been developed. The data collection tool is accessible on the JN+ website.

Some non-routine data sources used by the Jamiaca NHP include:

**KABP:** a population based survey of 15 to 49 year olds that provide information on sexual behaviour (e.g. condom use at last sex, transactional sex and abstinence), practices and knowledge about HIV. This has been conducted every 3 to 4 years since 1988. The most recent KABP was conducted in 2008.

**Second generation surveillance of SW and MSM:** A survey of SW was conducted in 2005 and 2008, 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 was conducted in 2007 and is being repeated in 2010. In addition, focus group discussions with MSM coupled with a systematic review of the literature were conducted in 2009 to provide a framework for development of a culturally appropriate intervention for Jamaican MSM.

**Workplace survey:** The survey of workplaces in 2006 involved assessment of provision of workplace policies and programs that address HIV/AIDS. It provided important baseline data and will be conducted in 2010.

**Multiple Indicator Cluster Survey (MICS):** The MICS is a household survey conducted by UNICEF with technical and financial support by the UN in Jamaica and a multiagency Steering Committee. This survey provides information on various health and social issues affecting women and children, including HIV/AIDS. The survey is conducted every 4 to 5 years (most recently done in 2005 and plans are afoot for 2010).

**Special studies:** Research is a priority for the NHP and provides an opportunity for evaluation of interventions and identification of priorities. For example, the PLACE studies in various regions of the island provided a template for targeted interventions and provided information on prevalence of STIs at some sites of socialization. Other studies being conducted are:

- An evaluation of the new guidelines for adherence is being conducted (2009 to 2010) by comparing adherence before and after the interventions.
- A study to determine the genetic diversity of HIV in Jamaica was conducted in 2009
- A consultant was recruited to conduct the UNAIDS protocol for Modes of transmission in 2009

- A survey of persons accessing VCT on world AIDS day 2008 was conducted to determine reasons for accessing outreach testing and the impact of VCT on HIV risk behaviours.

**Challenges**

Despite significant progress in quality and quantity of reports received by the M&E unit, the M&E system continues to face several challenges:

**Timeliness of reports** – Although stakeholder reporting have improved, late reporting continue to hampers data analysis and utilization. **Action:** A tracking matrix for stakeholder reports received was developed and monthly feedback to stakeholders on reports outstanding is a priority. The NHP also strives to improve data dissemination to stakeholders as a tool to improve reporting and stakeholder buy-in. The roll-out of the M&E operations manual in 2010 will improve timeliness and accuracy of reports.

**Underutilization of electronic databases** – many stakeholders continue to rely on paper-based forms despite provision of hardware and software for programme monitoring. This affects timeliness of report and the quality of data available for evaluation of programmes and tracking indicators. **Action:** Comprehensive workshops are planned for end users of databases to sensitize users on the M&E system, the indicators, the relevance and importance of reporting. In addition, a database administrator was hired to visit individual sites to identify and solve operational issues that may hamper implementation of databases. Technical assistance will be needed as networking and consolidation of databases are explored.

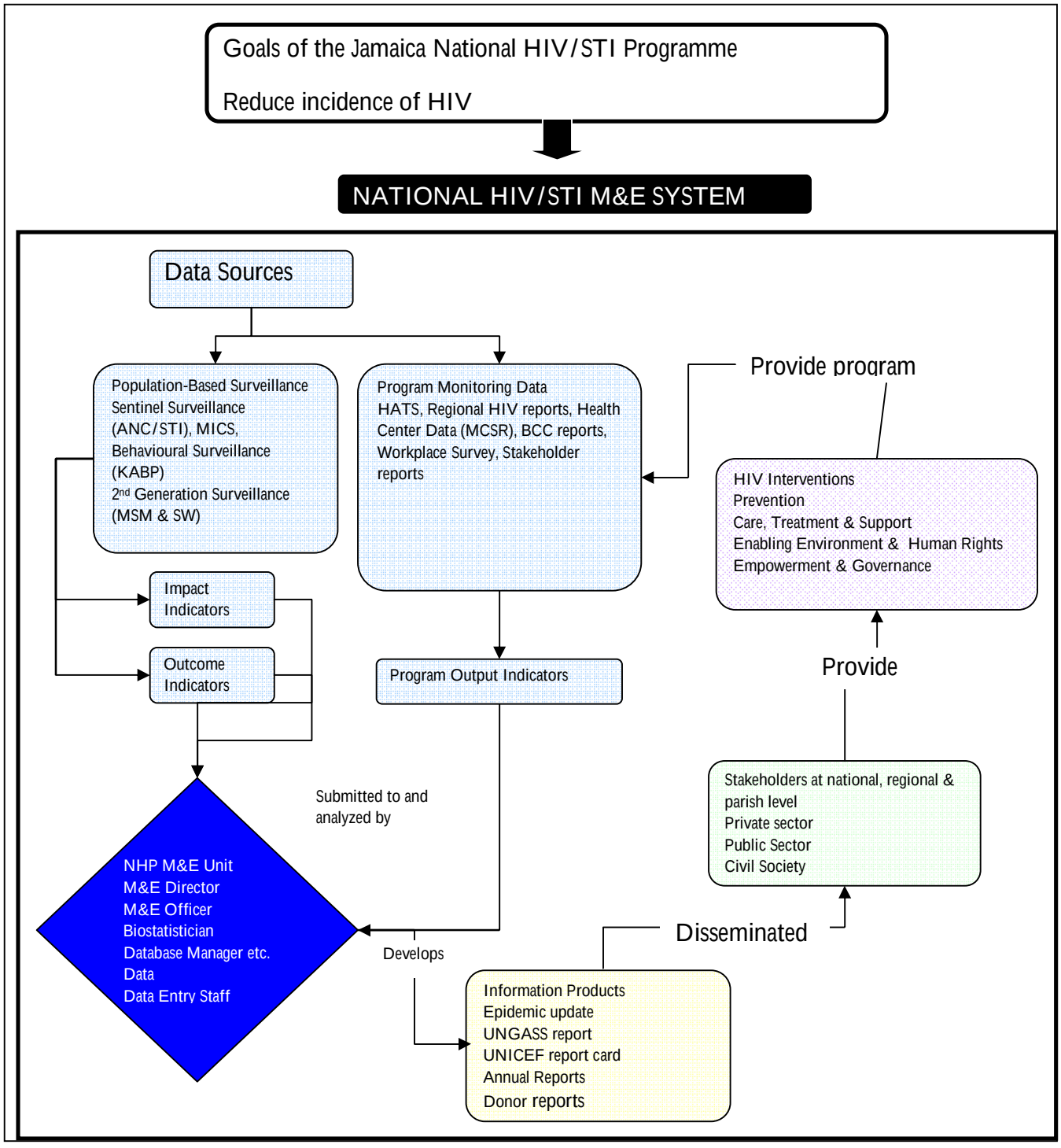
**Stakeholder capacity to conduct M&E** – the NHP continues to build capacity to conduct M&E through training workshops, technical assistance, provision of manuals and increased availability of M&E resources. However these efforts are hindered by the inconsistency of staff attending M&E meetings/workshops and the high turnover of staff in organizations such as NGOs. These factors contribute to inadequate use of data for decision making and an over-reliance on national level for interpretation and use of data. **Action:** Training workshops on M&E, data analysis and data utilization continue to be a priority for the M&E unit of the NHP. Participation in meetings at different levels of the system (regional, parish, clinic level etc.) with provision of technical assistance has been identified as a strategy. The NHP continues to draw on technical expertise for M&E resources, guidance on study and sampling methodology and improvement of M&E tools. **In particular, technical assistance will be necessary in designing studies for outcome and impact evaluation for MARPs and population size estimates.**

**Limited Human resources** – the M&E unit is challenged by the competing demands to establish a good M&E system while meeting the reporting requirements

of donors and international groups. As the HIV response expands and programme duration increases, determination of outcomes and impact of interventions have become priority. Yet the capacity to conduct evaluation studies is very limited and resources are channelled into other priorities. **Action:** Identification of courses for stakeholder M&E staff to further develop M&E skills and increasing availability of resources and technical assistance to stakeholders at all levels is a priority in 2010. This will be achieved by the establishment of a compendium of M&E resources and training opportunities by a technical working group of the MERG. In addition, resources will be identified to access training opportunities (e.g. IDP, NHP etc.).

**Limited data on MARPS** – During the last reporting period, surveys of MSM and SW were conducted giving insight into these populations. However, the data was limited by sampling methodology (convenience sampling) and small sample sizes. Data is lacking in other vulnerable populations such as substance users, mentally ill persons, disabled individuals and the homeless population. **Action:** Technical assistance will be sought to improve sampling methodology and study design. Collaborations with local groups working with these vulnerable populations (e.g. National Council of drug Abuse) are in progress to access and gather data on the epidemic in these groups.

**Figure 7:** Summary of the Jamaica M&E system



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## *ANNEX 1: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV/AIDS*

The data collection process for UNGASS 2010 reporting began after the 2008 UNGASS report was submitted. Activities leading up to 2010 reporting are summarized below in Table 5.

| Activity | Start date | Completion |
|---|---|---|
| Identify data needs in line with the national strategic plan requirements and these UNGASS guidelines. | Dec-07 | On going |
| • Develop a plan for data collection, analysis and report writing | Jan-08 | Feb-08 |
| • Secure required funding for the entire process of collecting, analysing and reporting the data. | Mar-08 | 31-Dec-09 |
| • Collect and collate and analyse data in coordination with partner organizations | Jan-08 | on going |
| • Draft the Country Progress Report narrative. | Nov-09 | Feb-10 |
| • Allow stakeholders, including government agencies and civil society, to comment on the draft report. | 10-Feb-10 | 24-Feb-10 |
| • Validate data against the narrative and enter it into the UNGASS reporting website | Jan-10 | 31-Mar-10 |
| • Submit (i) the narrative report and (ii) the indicator data to UNAIDS Geneva before 31 March | 22-Mar-10 | 31-Mar-10 |

**Table 5**: Timelines for drafting 2010 UNGASS report

Discussions and reflections on the Core Indicators have occurred at numerous stakeholders meetings during the reporting period. These include the National HIV/STI Programme's annual review, meetings of the CCM, monthly team meetings (prevention, treatment care & support, and policy) and regional BCC retreats. Two other major stakeholder meetings were used to reflect on the findings of the UNGASS 2010 preparation process: the meeting of the Jamaica MERG in December 2009 and a National stakeholder meeting on March 5, 2010.

The March 2010 stakeholder meeting brought together more than 60 stakeholders including government ministry representatives, NGOs, IDP representatives, FBOs, regional health authorities and PLHIV. This forum was used to gain consensus on the NCPI and review the draft UNGASS report in order to identify gaps and areas of concern. The comments of the group were incorporated in the draft report which was subsequently circulated for further feedback prior to submission to UNGASS.

## *ANNEX 2: National Composite Policy Index Indicator trend Analysis2003 -2009*

| NCPI KEY INDICATORS | Period 2003 | 2005 | 2007 | 2009 |
|---|---|---|---|---|
| NCPI-A-I : Country has developed a national multi-sectoral strategy/action framework to combat HIV/AIDS | | Yes | Yes | Yes |
| NCPI-A-I : Country has integrated HIV/AIDS into its general development plans | | Yes | Yes | Yes |
| NCPI-A-I : Country has evaluated the impact of HIV and AIDS on its socio economic development for planning purposes | | Yes | Yes | No |
| NCPI-A-I : Country has a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services, military, peacekeepers and police | | Yes | Yes | Yes |
| NCPI-A-I-R : Strategy planning efforts in the HIV and AIDS programmes overall Rating | 7 | 8 | 8 | 9 |
| | | | | |

| | | | | |
|---|---|---|---|---|
| NCPI-A-II : The head of the government and/or other high officials speak publicly and favourably about AIDS efforts at least twice a year | | Yes | Yes | Yes |
| NCPI-A-II : Country has a national multisectoral HIV and AIDS management/coordination body recognized in law? (National AIDS Council or Commission) | | Yes | Yes | Yes |
| NCPI-A-II : Country has a national HIV and AIDS body that promotes interaction between government, people living with HIV, the private sector and civil society for implementing HIV and AIDS strategies/programmes | | Yes | Yes | Yes |
| NCPI-A-II : Country has a national HIV and AIDS body that is supporting coordination of HIV-related service delivery by civil-society organizations | | Yes | Yes | Yes |
| NCPI-A-II-R : Political support for the HIV/AIDS programme overall rating | | 7 | 8 | 7 |

| | | | | |
|---|---|---|---|---|
| NCPI-A-III : Country has a policy or strategy that promotes information, education and communication (IEC) on HIV and AIDS to the general population | | Yes | Yes | Yes |
| NCPI-A-III : Country has a policy or strategy promoting HIV and AIDS related reproductive and sexual health education for young people | | Yes | Yes | Yes |
| NCPI-A-III : Country has a policy or strategy to promote information, education and communication and other preventive health interventions for most-at-risk populations | | Yes | Yes | Yes |
| NCPI-A-III : Country has a policy or strategy to expand access, including among most-at-risk populations, to essential preventative commodities. (These commodities include, but are not limited to, access to confidential voluntary counselling and testing, condoms, sterile needles and drugs to treat sexually transmitted infections.) | | Yes | Yes | Yes |
| NCPI-A-III-R : Policy efforts in support of prevention overall rating | 4 | 6 | 7 | 6 |
| NCPI-A-III : Prevention activities have been implemented during the period in support of the HIV-prevention policy/strategy | Yes | Yes | Yes | Yes |
| | | | | |

| | | | | |
|---|---|---|---|---|
| NCPI-A-III-R2 : Efforts in the implementation of HIV prevention programmes overall rating | 6 | 7 | 8 | 9 |
| | | | | |
| NCPI-A-IV : Country has a policy or strategy that promotes information, education and communication (IEC) on HIV and AIDS to the general population | | Yes | Yes | Yes |
| NCPI-A-IV : Activities have been implemented under the care and treatment of HIV and AIDS programmes | Yes | Yes | Yes | Yes |
| | | | | |
| NCPI-A-IV : Efforts in care and treatment of the HIV/AIDS programme overall rating | 6 | 8 | 9 | 9 |
| | | | | |
| NCPI-A-IV : Country has a policy or strategy to address the additional HIV and AIDS-related needs of orphans and other vulnerable children (OVC) | | Yes | Yes | Yes |
| NCPI-A-IV-R2 : Efforts to meet the needs of orphans and other vulnerable children overall rating | 6 | 7 | 8 | 7 |
| | | | | |
| NCPI-A-V: Country has one national Monitoring and Evaluation (M&E) plan | | In Progress | Yes | Yes |

| | | | | |
|---|---|---|---|---|
| NCPI-A-V : There is a budget for the Monitoring and Evaluation plan | | Yes | Yes | Yes |
| NCPI-A-V : There is a Monitoring and Evaluation functional Unit or Department | | Yes | Yes | Yes |
| NCPI-A-V : There is a committee or working group that meets regularly coordinating Monitoring and Evaluation activities | | In Progress | Yes | Yes |
| NCPI-A-V : Individual agency programmes have been reviewed to harmonize Monitoring and Evaluation indicators with those of your country | | Yes | Yes | Yes |
| NCPI-A-V : Degree (Low to High) to which UN, bi-laterals, other institutions are sharing Monitoring and Evaluation results? | | 6 (0.6) | 4 (out of 5) (0.8) | Information not requested in 2009 |
| NCPI-A-V : The Monitoring and Evaluation Unit manages a central national database | | Yes | Yes | Yes |
| NCPI-A-V : There is a functional Health Information System | | Yes | No | Yes |
| NCPI-A-V : There is a functional Education Information System | | Yes | - | - |

| | | | | |
|---|---|---|---|---|
| NCPI-A-V : Country publishes at least once a year an evaluation report on HIV and AIDS, including HIV surveillance reports | | Yes | Yes | Yes |
| NCPI-A-V : Extent to which strategic information is used in planning and implementation? | | 8 | 4(out of 5) (0.8) | 4(out of5) (0.8) |
| NCPI-A-V : In the last year, training in Monitoring and Evaluation was conducted | | Yes | Yes | Yes |
| NCPI-A-V-R : Monitoring and evaluation efforts of the HIV and AIDS programme overall rating | 6 | 7 | 9 | 9 |
| NCPI-B-I : Country has laws and regulations that protect people living with HIV and AIDS against discrimination | | Yes | No | No |
| NCPI-B-I : Country has non-discrimination laws or regulations which specify protections for certain groups of people identified as being especially vulnerable to HIV and AIDS discrimination | | No | Yes | No |
| NCPI-B-I : Country has laws and regulations that present obstacles to effective HIV prevention and care for most-at-risk populations | | No | Yes | Yes |

| | | | | |
|---|---|---|---|---|
| NCPI-B-I : The promotion and protection of human rights is explicitly mentioned in an HIV and AIDS policy/strategy | | Yes | Yes | Yes |
| NCPI-B-I : The Government has, through political and financial support, involved vulnerable populations in governmental HIV-policy design and programme implementation | | Yes | Yes | Yes |
| NCPI-B-I : Country has a policy to ensure equal access, between men and women, to prevention and care | | Yes | Yes | Yes |
| NCPI-B-I : Country has a policy to ensure equal access to prevention and care for most-at-risk populations | | Yes | Yes | Yes |
| NCPI-B-I : Country has a policy prohibiting HIV screening for general employment purposes (appointment, promotion, training, benefits) | | Yes | Yes | Yes |
| NCPI-B-I : Country has a policy to ensure that HIV and AIDS research protocols involving human subjects are reviewed and approved by a national/local ethical review committee | | Yes | Yes | Yes |
| NCPI-B-I : Country has monitoring and enforcement mechanisms | | Yes | Yes | Yes |
| NCPI-B-I : Members of the judiciary have been trained/sensitized to HIV and AIDS and human rights issues that may come up in the context of their work | | No | Yes | Yes |
| NCPI-B-I : Legal support services are available in the country | | Yes | Yes | Yes |

| | | | | |
|---|---|---|---|---|
| NCPI-B-I : There are programmes designed to change societal attitudes of discrimination and stigmatization associated with HIV and AIDS to understanding and acceptance | | Yes | Yes | Yes |
| NCPI-B-I-R : Policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS overall rating | | 5 | 6 | 6 |
| NCPI-B-I-R2 : Effort to enforce the existing policies, laws and regulations overall rating | | 3 | 4 | 5 |
| | | | | |
| NCPI-B-II : Extent to which civil society has made a significant contribution to strengthening the political commitment of top leaders and national policy formulation | | 8 (0.8) | 2 (out of 5) (0.4) | 3(out of 5) (0.6) |
| NCPI-B-II : Extent to which civil society representatives have been involved in the planning and budgeting process for the National Strategic Plan on HIV and AIDS or for the current activity plan (attending planning meetings and reviewing drafts) | | 7 (0.7) | 2 (out of 5) (0.4) | 3(out of 5) (0.6) |
| NCPI-B-II : Extent to which the complimentary services provided by civil society to areas of prevention and care are included in both the National Strategic plans and reports | | 7 (0.7) | 3 (out of 5) (0.6) | 3 planning (out of 5) (0.6)<br>4 reports (out of 5) (0.8) |

| | | | | |
|---|---|---|---|---|
| NCPI-B-II : Country has conducted a National Periodic review of the Strategic Plan with the participation of civil society | | Yes | Yes | - |
| NCPI-B-II : Extent to which country has a policy to ensure that HIV and AIDS research protocols involving human subjects are reviewed and approved by an independent national/local ethical review committee in which people living with HIV and caregivers participate | | 9 | Information not requested | Information not requested |
| NCPI-B-II-R : Efforts to increase civil-society participation overall rating | 5 | 8 | 8 | 7 |
| | | | | |
| NCPI-B-III-1 : Prevention activities have been implemented in 2003 and 2005 in support of the HIV-prevention policy/strategy | Yes | Yes | Yes | Yes |
| NCPI-B-III-R : Efforts in the implementation of HIV prevention programmes overall rating | 6 | 7 | - | 8 |
| | | | | |
| NCPI-B-IV : Activities have been implemented under the care and treatment of HIV and AIDS programmes | Yes | Yes | Yes | Yes |
| NCPI-B-IV-R : Efforts in care and treatment of the HIV/AIDS programme overall rating | 6 | 9 | 8 | 8 |
| NCPI-B-IV : Country has a policy or strategy to address the additional HIV and AIDS-related needs of orphans and other vulnerable children (OVC) | | Yes | Yes | Yes |

| | | | | |
|---|---|---|---|---|
| NCPI-B-IV-R2 : Efforts to meet the needs of orphans and other vulnerable children overall rating | 5 | 8 | 8 | 5 |

* Where rating scales across the years are different a consistent measure is inserted