Jamaica

National HIV Strategic Plan

2012 – 2017

National HIV/STI Programme

Draft 8 August 2011

Foreward

Prime Minister

Minister of Health

Table of Contents

List of Tables

List of Figures

Acronyms

Executive Summary

1 The HIV Epidemic in Jamaica

The adult HIV prevalence in Jamaica was 1.7% in 2011 with an estimated 32,000 persons living with HIV (PLHIV) (UNAIDS 2010, Table 1). Approximately one half of these persons were unaware that they were infected with HIV. Over the past decade UNAIDS assessed that there was a 25% decline in new HIV infections in Jamaica. However, as many as 2,100 Jamaicans are estimated to become newly HIV infected each year and AIDS remains a leading cause of death among adults 15-49 years with over 500 reported deaths due to AIDS in 2010.

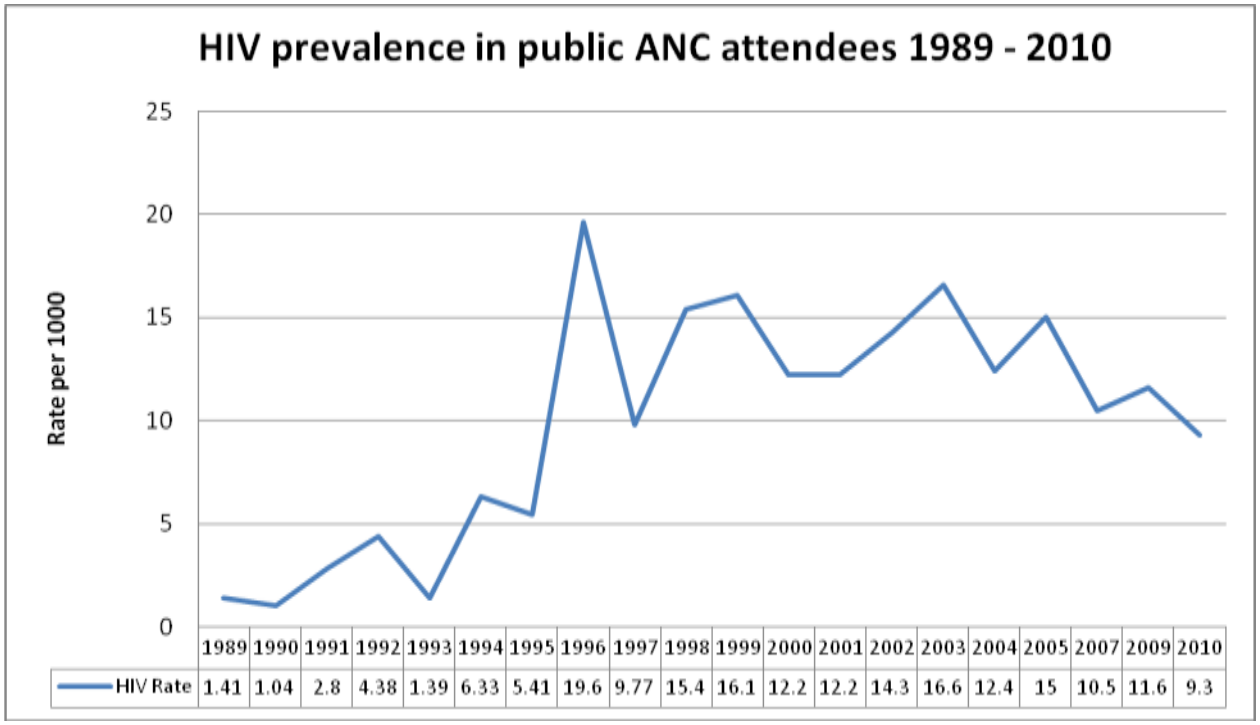
The HIV epidemic in Jamaica is characterised as being a mixed epidemic because it shows features of being both generalized in the population and concentrated among those who are most at risk. While HIV prevalence has been less than 2% in the general population and relatively stable for many years the prevalence of HIV among those most at risk remains unacceptably high. Among men who have sex with men (MSM) HIV prevalence has been estimated as 32% for over 15 years (Figueroa 2011). HIV prevalence among female sex workers (SW) was 9% in 2005 and 4.9% in 2008; among prison inmates 4.8%, the homeless 10% and crack/cocaine users 5% (Duncan et al , Ministry of Health, Jamaica 2010, Figueroa et al 2008, UNAIDS 2010).

Table 1 Epidemiological Profile: HIV/AIDS Indicators

Indicators	Jamaica
HIV prevalence in persons aged 15-49	1.7% (2010) UNAIDS estimate 0.93% (2010) ANC surveillance (preliminary)
HIV prevalence among female sex workers (SW)	9.0% (2005) 4.9% (2008)
HIV prevalence among men who have sex with men (MSM)	31.8% (2007) 32.2% (2011)
HIV prevalence among crack/cocaine users	5% (2009)
HIV prevalence among homeless persons	12.0% (2010) 8.2% (2011)
HIV prevalence rate among STI clinic attendees	3.6% (2007) 2.8% (2010)
Reported AIDS deaths	514 (2009) __ (2010)

HIV Prevalence in the General population

Historically, HIV prevalence among pregnant women in public antenatal clinics (ANC) has been used to estimate the prevalence of HIV in the general population. During the 1990s HIV prevalence increased rapidly among public ANC attendees peaking at 1.96% in 1996 (Figure 1). Between 1997 and 2005 HIV prevalence among ANC attendees was relatively stable at 1.5% with a decline to 0.93% in 2010. The actual HIV prevalence among all pregnant women in Jamaica is likely to be lower since HIV infection appears to be less common among the 30% of pregnant women seeking private antenatal care. There have been no population based surveys of HIV in Jamaica. When outreach HIV testing has been conducted among the public newly diagnosed HIV infections were usually 1%-2% of those tested.

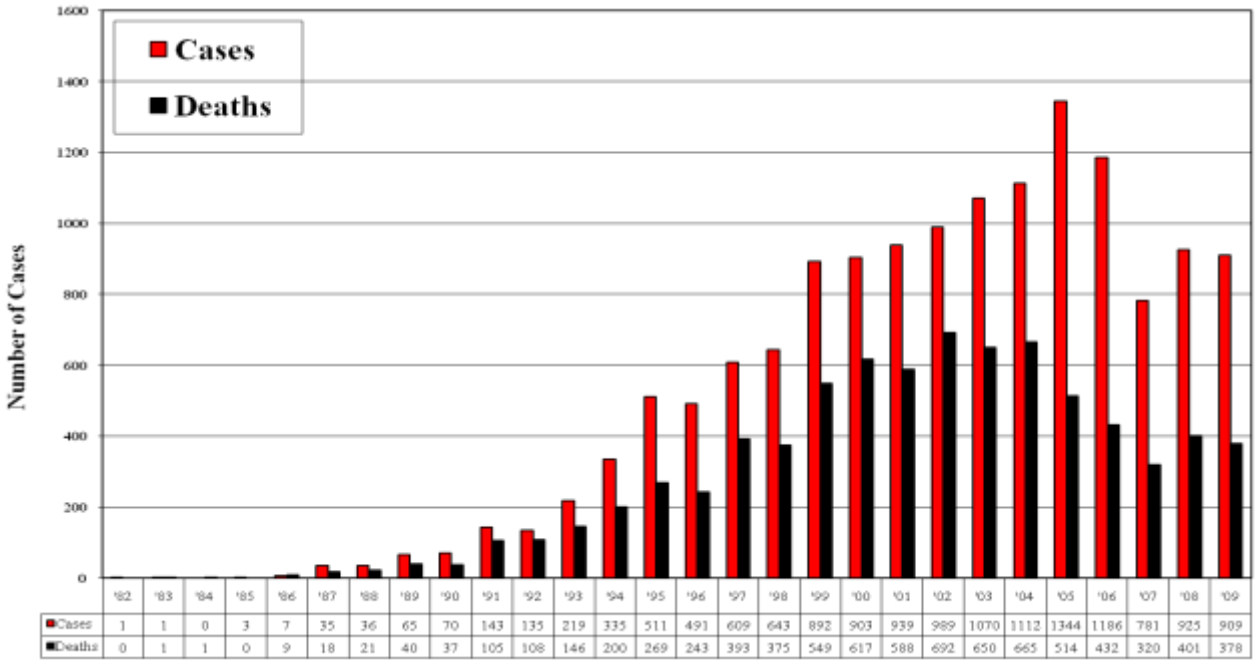


	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2007	2009	2010
HIV Rate	1.41	1.04	2.8	4.38	1.39	6.33	5.41	19.6	9.77	15.4	16.1	12.2	12.2	14.3	16.6	12.4	15	10.5	11.6	9.3

Figure 1: HIV prevalence among public antenatal clinic attendees in Jamaica 1989-2010

Reported AIDS Cases and AIDS Deaths

The first case of AIDS was reported in Jamaica in 1982. Initially, the number of AIDS cases reported annually was small. However, the number of reported AIDS cases increased steadily and peaked with 1344 AIDS cases in 2005 (Figure 2). Since then, the number of reported AIDS cases has declined markedly due to the introduction of a public access anti-retroviral (ARV) treatment program in 2004 which has significantly reduced morbidity and mortality due to AIDS and prolonged the life of persons living with HIV. Reported AIDS deaths increased annually and peaked in 2002 with 692 AIDS deaths. There was a steep decline in AIDS deaths annually with 320 reported in 2007. Since then AIDS deaths have increased somewhat. It is known that both AIDS cases and deaths due to HIV infection and AIDS are under reported in Jamaica. The extent of under reporting is not known.



	'82	'83	'84	'85	'86	'87	'88	'89	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	'09
Cases	1	1	0	3	7	35	36	65	70	143	135	219	335	511	491	609	643	892	903	939	989	1070	1112	1344	1186	781	925	909
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	378

Figure 2**: Reported AIDS Cases and AIDS Deaths annually in Jamaica 1982-2009**

By the end of 2009, the cumulative number of persons reported with AIDS in Jamaica was 14,354 and the cumulative number of AIDS deaths was 7,772. (*Appendix*). Young adults continue to be most affected by HIV with approximately 79% of all reported AIDS cases in Jamaica occurring in the 20-49 year old age group, and 90% of all reported AIDS cases aged between 20 and 60 years. AIDS case rates among men continue to exceed AIDS case rates among women. Surveillance data indicate that the sex difference is narrowing as women accounted for 37% of persons reported with AIDS prior to 1995 compared to 44% of persons reported with AIDS between 2004 and 2008 (Duncan et al, 2010). There were considerably more reported AIDS cases in 2010 among girls and young women than among boys and young men.

All 14 parishes are affected by the HIV epidemic (Figure 3) but the most urbanized parishes have the highest cumulative number of reported AIDS cases (St. James – 1,176 AIDS cases per 100,000 persons and Kingston & St. Andrew – 822 cases per 100,000 persons). In 2009, the parishes of St. James, St. Catherine and Kingston & St. Andrew reported the highest number of cases of HIV infection in Jamaica. However, parishes such as ST. Ann and Trelawny also recorded significant increase in 2009 compared to the previous year. In 2009, the cumulative reported AIDS cases (1982-2009) ranged from 224 per 100,000 people in Clarendon to 1,176 per 100,000 persons in St. James.

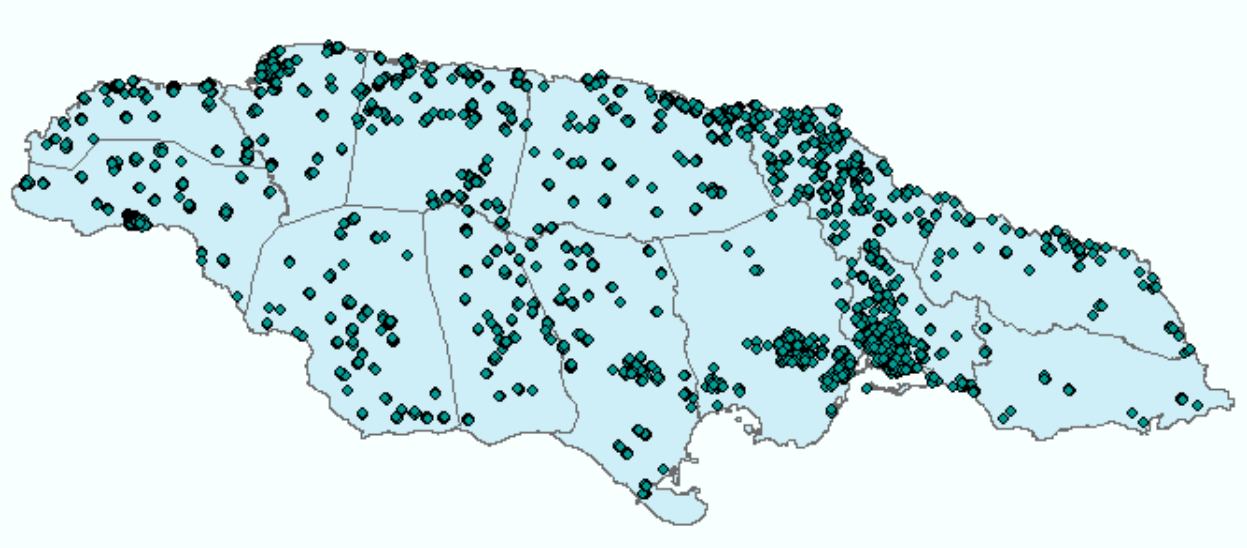


Figure3: Distribution of HIV and AIDS Cases by Parish in Jamaica, 1982 – 2010

[5900 cases mapped to date; include an updated map once Mona GIS completes mapping]

Transmission Categories

The HIV epidemic continues to be transmitted primarily through sexual intercourse, with 90% of persons reported with AIDS citing heterosexual practice. Among men on whom data on sexual activity are available, 86% reported having only female sex partners while 14% reported having male sex partners. However, the sexual practice of 40% of men with AIDS is unknown and may reflect under reporting by MSM who are unwilling to reveal their sexual practices as well as incomplete reporting. The unavailability of data on the sexual practice of over 40% of the males reported with AIDS is a significant weakness in the surveillance system. The high rates of HIV infection and bisexuality among MSM are likely to be important factors currently driving the HIV epidemic in Jamaica.

Approximately 80% of persons with AIDS reported having multiple sex partners and 45% reported ever having a sexually transmitted infection (STI). 20% reported commercial sex, 6.3% crack/cocaine use and 0.8% injecting drug use which was assessed as being done primarily while the person was abroad. Approximately 20% of persons with AIDS did not report having any risk factor for HIV infection. Most of these persons were women who were probably infected by their male sex partner.

Access to HIV Testing and ARV Treatment

Of the estimated 32,000 PLHIV in Jamaica in 2010 approximately 14,000 were in need of ARV treatment. Since the public access programme to antiretroviral treatment (ART) was introduced in 2004, approximately 1,000 to 1,500 new persons were placed on treatment each year. By the end of 2010, 7560 adults and 487 children with HIV were started on ARV treatment. The rapid expansion of ART has resulted in a decline in reported AIDS cases and AIDS deaths between 2004 and 2009 by 17% and 40% respectively (Figure 2). The benefits of ART extend beyond delaying disease progression and AIDS death, but also reduce HIV transmission to HIV negative partners. Achieving universal access to ART will reduce the number of new HIV infections and contribute to the declining trend in HIV incidence.

The introduction of opt out HIV testing in public antenatal and STI clinics, and the use of rapid HIV testing has impacted favourably on the HIV epidemic in Jamaica. The number of HIV tests done annually has more than doubled from less than 100,000 tests per year prior to 2004 to over 200,000 HIV tests per year since 2006. Increased access to HIV testing has contributed to earlier diagnosis of PLHIV and timelier access to ARV treatment resulting in improved survival. The 12 month survival of PLHIV who initiated ARV treatment in 2009 was 88%. The proportion of persons first diagnosed and reported at AIDS or AIDS death has declined from 30% prior to 2004 to 14% after 2004 ($p<0.0001$)(Ref).

Many of the PLHIV who are unaware of their HIV status are not being identified because of the failure of the health services to offer provider initiated testing to all persons attending accident and emergency departments and all persons admitted to hospital. In 2010 _% of hospital admissions tested were HIV positive. Persons who are unaware of their HIV status are likely to play an important role in transmitting HIV infection. Women account for 66% of all HIV tests done in the health regions and 53% of PLHIV accessing ARV at public treatment sites.

Prevention of mother to child HIV transmission

Opt-out HIV testing for pregnant women is available in both public and private health sectors. National surveys show that 91% women who were pregnant within the last 2 years had received HIV testing and counselling and 67% were aware of medication to prevent mother to child transmission of HIV (Reproductive Health Survey, 2008). Nearly all (95%) pregnant women attending public clinics in 2010 were tested for HIV. Most (87%) HIV infected pregnant women and 98% of HIV exposed infants received ARV medication in order to prevent mother to child transmission in 2010 (Table 2). The success of the programme is reflected in the low mother to child transmission rate of 4.3% (JAPAIDS, 2011). The number of reported paediatric AIDS cases has declined from 61 cases in 2004 to 26 in 2009. The cumulative number of paediatric AIDS cases reported in 2009 was 932.

Despite these gains approximately 15% of HIV infected pregnant women continue to elude the programme because they present late for delivery and are not HIV tested or they do not reveal their status to the health staff. In addition, some HIV exposed infants become lost to follow up.

Table 2 Prevention of mother to child HIV transmission in Jamaica 2005-2010

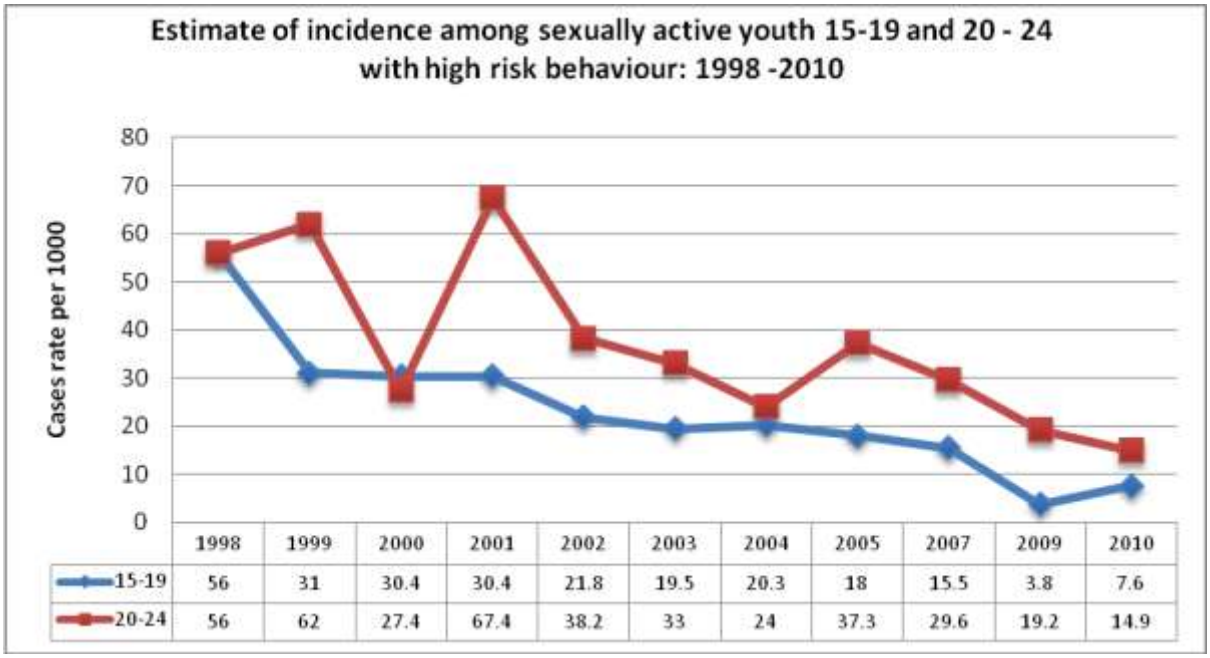
	2005	2006	2007	2008	2009	2010*
# ANC Attendees Tested	28,651 (96%)	28,446 (95%)	22,478 (95%)	28,659 (>95%)	30,076	20,259
# HIV +ve women delivered	401	442	358	616	440	404
% of women getting ARVs	**74%**	**84%**	**84%**	**84%**	**84%**	**87%**
# of HIV – exposed infants	407	433	362	612	439	392
# Infants getting PMTCT	**353 (87%)**	**403 (93%)**	**350 (97%)**	**605 (98%)**	**430 (98%)**	**383 (98%)**
Transmission Rate	**10%**	**<10%**	**<5%**	**<5%**	**4.3%**	Pending

Factors driving the Epidemic: Behavioural, Social and Cultural

Behavioural factors driving the HIV epidemic include multiple sexual partnerships, early sexual debut, high levels of transactional sex, commercial sex and inadequate condom use. These risk behaviours are significantly higher among men than women although women tend to under report risk behavior more than men due to social acceptability bias. Sexual risk behaviours tend to be more culturally acceptable for men than for women.

A 2008 national survey of the knowledge, attitudes, beliefs and practices (KABP) of the general population found that among sexually active respondents 61.5% of men and 16.8% of women reported having more than one sex partner in the last 12 months. Over a half (52.7%) of sexually active men and 21.0% of women admitted to participating in transactional sex. 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). Reported condom use was suboptimal with 64.5% of men and 52.1% of women with multiple partners saying that they used a condom at last sex. Although they had access to condoms, significant numbers of men and women reported not using a condom at last sex. Despite many HIV prevention education programmes, HIV knowledge indicators have not improved significantly over the last decade with 37.4% of men and 42.3% of women appropriately identifying how to prevent HIV and rejecting myths in 2008.

Adolescents and Young People: Population estimates for 2010 show 277,380 adolescents, 10 -14, and 458,854 youth age 15-24 in Jamaica. A 2005 survey of in-school children (10 to 15 years old) found that 12% of surveyed adolescents were sexually active and of these, 56% had two or more partners (including 18% of respondents who had 6 or more partners). Half (48%) of male students reported no condom use at last sex. Although most adolescents agreed to their first sexual experience, 9% of boys and 24% of girls reported that they were forced to have sex on their first sexual encounter. Similarly, the 2008 reproductive health survey found that one in every five sexually active girl, 15-19 years, is forced to have sex. Among the youth surveyed in the most recent national KABP survey (2008) over 60% were sexually active.



	1998	1999	2000	2001	2002	2003	2004	2005	2007	2009	2010
15-19	56	31	30.4	30.4	21.8	19.5	20.3	18	15.5	3.8	7.6
20-24	56	62	27.4	67.4	38.2	33	24	37.3	29.6	19.2	14.9

Figure 4 Estimated HIV incidence among sexually active youth in Jamaica 1998-2010

Despite the persistence of high-risk behaviour among our youth – multiple partners, unprotected sex with non-regular partners, and early sexual debut- the incidence of HIV among high-risk youth continues to trend downwards. This is a positive indication, as it suggests that efforts to control the growth of HIV in the general population in Jamaica have been successful. However, this HIV rate remains high.

Populations Most at Risk of HIV

As stated previously, the Jamaican epidemic has features of a generalised and a concentrated epidemic. The key groups that constitute the concentrated epidemic are female sex workers, male clients of sex workers, men who have sex with men, the homeless, and inmates. EPP/Spectrum software (UNAIDS, 2011) was used to produce models of the HIV the epidemic in these key populations, including projections of the trends up to 2015. Projections of the epidemic in the key populations are derived from past trends in prevalence, transmission, incubation period, and targets for HAART.

Sex Workers: It is estimated that 12,000 female sex workers (SW) operate in Jamaica at any given time. This population is characterized by high levels of mobility, multiple sexual contacts, low condom use with their regular partner and high levels of substance use. A survey of SW operating in bars, clubs and on the street in 2008 found that condom use with clients (97%) was significantly higher than condom use with non-paying partners (23%). HIV prevalence was found to be 4.9% in this population and 56% of this population had at least one STI. Substance use was also high in this population with 55% club-based SW using alcohol daily and 35% using ecstasy. The UNAIDS model shows no decline in the projected number of new HIV infections associated with sex work in Jamaica in the foreseeable future.

MSM: The MSM population is estimated to be 28,000. A survey of 201 MSM in 2001 and of 400 MSM in 2011 both found an HIV prevalence of 32% (Figueroa et al 2011) which is considerably higher than the 10% HIV prevalence in a sample of 125 MSM in 1985 (Murphy et al 1988)**.** In the 2007 survey many (56.7%) MSM had at least one female partner in the past 12 months and 27.4% had multiple male partners within the last 4 weeks. 57.7% had ever done an HIV test and 32.9% had done so in the past 12 months. 67% reported using a condom at last sex with their main male partner while 62% reported doing so at last sex with a female partner. These findings suggest that men who have sex with men and women function as a bridge population and may account for the increasing rate of HIV seen in women.

The UNAIDS projection model does not indicate any meaningful decline in new HIV infections among MSM over the next few years. Given the large number of MSM who are HIV infected, the frequency of multiple partnerships and condom use patterns, the high HIV prevalence will be maintained or even increase if meaningful behaviour change is not achieved within this strategic planning period. More effective ways need to be found to reduce the high prevalence of HIV among MSM in Jamaica including measures to reduce their social vulnerability, combat stigma and discrimination and empower them to practice safe sex.

Clients of Sex workers: The HIV prevalence of persons attending public STI clinics is used to estimate prevalence among clients of sex workers and other persons from the general population who exhibit high-risk behaviours. In 2010, approximately 90,000 visits to public STI clinics were recorded. Sentinel surveillance of public STI clinic attendees shows that HIV prevalence increased from 3% in 1990 to 4.6% in 2005 and then declined significantly to 2.4% in 2009. Using the UNAIDS model the HIV prevalence in this population has decreased since 1999 and is projected to continue to decline.

Prison Inmates: An estimated 4,600 persons were incarcerated in Jamaica 2011. A 2006 survey of prison inmates found an HIV prevalence of 3.3% (Andrinopoulos et al 2010). Surveillance of new inmates in the last 3 years has recorded similar levels of HIV prevalence namely 4.3% in 2010 and 1.8% in 2011.

Homeless: A survey of homeless persons in Kingston in 2009 found 34% of homeless women and 9% of homeless men were HIV positive (Abel et al). Substance abuse was high in this population with 59% men and women reporting substance use.

Conclusion

The number of new HIV infections in Jamaica has declined by 25% in the past decade (UNAIDS). HIV prevalence among public antenatal and STI clinic attendees has declined. However, HIV prevalence among MSM remains very high at 32% and high among female sex workers at 4.9%. This suggests that interventions designed to reduce the number of new HIV infections have achieved some degree of success among the general population.

In contrast, the rates of HIV infection among those who are most at risk remain unacceptably high, and among MSM show no sign of abatement. High prevalence levels persist despite significant scaling up of targeted interventions with MSM and Sex Workers. Interventions with homeless and inmates are evolving and their impact is yet to be seen.

The HIV epidemic profile of Jamaica shows a shift from a generalized epidemic to one in which HIV infections are largely concentrated in key high risk groups. Strategies that focus on these groups will have the greatest impact on changing the course of the epidemic.

2 The Socio-economic Context

Multisectoral response

Sustaining an effective multi-sectoral response to the HIV epidemic remains a priority for Jamaica. This has been an abiding principle of the National HIV/STI Control Programme since its inception and has been included in every National HIV Strategic Plan.

Every sector must adopt policies, actions and budgets that integrate its response to the HIV epidemic into the regular operations of the sector. A collective evidence based response to HIV would result in the infusion of HIV policies and activities in sector and national development plans thereby harmonizing and strengthening the national response to the epidemic. A fundamental aim of such an approach would be to achieve strategic development goals in a way that reduces social vulnerability to HIV, affirms the rights of all our citizens and provides a supportive environment for those most at risk and those living with or affected by HIV.

Factors driving the Epidemic

The primary determinants of social vulnerability to HIV are structural. These include poverty, social inequity; gender norms, social exclusion and marginalization; and the policy and legislative environment. These factors are often institutionalized through long-standing structural mechanisms that have become a part of the culture. Articulating a clear vision, strong political will and commitment, long term planning and evidence based strategies are all needed in order to achieve the required changes.

An example of a structural mechanism that has become culturally entrenched that has had a significant adverse impact on Jamaica's HIV epidemic is the criminalization of persons based on sexual orientation, and their stigmatization and marginalization. This stigma and discrimination contributes to risk taking behaviour among those persons who feel demeaned and rejected by society. It also sustains a climate where persons are reluctant to disclose their sexual orientation or their HIV status which drives the epidemic underground and increases the risk of HIV spread.

Macroeconomic Performance and impact on HIV epidemic

From a macroeconomic standpoint Jamaica's economy continues to contract, thereby compromising the achievement of national development goals. Jamaica's poor economic performance over many years was due to several factors including structural imbalances in the economy, the effects of globalisation and the global economic crisis, poor fiscal management over the years; high rates of crime and violence and natural disasters.

The Planning Institute of Jamaica (PIOJ) projected that poverty levels in Jamaica increased to 18.5%-20.3% in 2010, up from 16.5% in 2009, and 12.3% in 2008. In 2010 Jamaica's population stood at 2,705,800(STATIN 2010). This means that approximately 500,000 Jamaicans currently are living below the poverty line. The weakening of Jamaica's human capital is particularly worrying given the link between risky sexual behaviour and widening social inequity caused by unemployment, wide income disparities, lack of access to credit, and poor economic growth.

Sectoral performance & impact on HIV epidemic

The response of key sectors to the epidemic has been the main focus of the National HIV Program in the past. As the epidemic matures and economic performance continues to be weak, sector specific issues must be addressed in order to mitigate the impact of the epidemic and reduce HIV vulnerability. Of crucial concern are employment, education, health, food security and social welfare.

Employment /Unemployment

In 2010 STATIN reported increases in both male and female unemployment. Male unemployment increased from 8.6% in 2009 to 9.2% while female unemployment increased from 14.8% to 16.2%. Unemployment for youth (14 –24 years) and Adults (25 years and over) also increased 30.8 % and 9.7% respectively. The minimum wage remained the same during the 2009/10 financial year.

The 2008 Survey of Living Conditions reports that women are disproportionately represented among the poor. The high levels of unemployment among women and their larger household size undermines their economic independence and makes them more dependent on males for economic stability. This may contribute to more risky sexual behaviour among women due to unprotected sex, transactional sex or an increase in the number of sexual partnerships (UNAIDS, Wyatt 1992, Le Franc 1996).

The lower levels of employment for females in the 14-24 age group is also of concern based on its association with intergenerational and transactional sex. A study conducted by Kempadoo and Dunn (2001) found respondents referring to "big men" such as drug dealers or taxi drivers as attractive for some young girls because they provide clothes, gifts, and free rides. Some parents prefer to close their eyes to these inter-generational relationships because of financial gain (Hutchinson et al 2007). Bombereau and Allen (2008) cite Chambers and Mitchell-Kernan's study in Jamaica (1993) which describes "red-eye sex". This refers to girls and women whose basic needs are already met yet they have sex in exchange for improved social status and material items such as fine shoes, jewellery, brand name goods and clothes that are status symbols.

Education/Illiteracy

School enrollment is high in Jamaica and adult illiteracy is reported as 91.7% (2008 Survey of Living Standards). The reported gross enrolment rates at pre-primary, primary, secondary and tertiary were 99.6 %, 92.1 %, 94.5 % and 32.8 %, respectively (PIOJ). However, there are serious inequities with respect to the quality of education. For instance, only 53.0 % of the poorest have the required texts

compared with 91.7 % of the wealthiest; and children in rural areas are less likely to have all their textbooks (66.7 %) compared with their peers in the Kingston Metropolitan Area (77.2 %). Labour force certification is low at just over 20%. Low literacy and poor education do contribute to increased HIV vulnerability.

Social Welfare

By 2008, nearly 50% of persons who had ever applied to PATH (conditional cash transfer programme) had received the benefit. Beneficiaries in the poorest quintiles (1 and 2) accounted for 69.7% of these recipients, a decline over the previous year and therefore indicative of greater leakage to households in wealthier quintiles. Approximately 30% of the poor are not accessing and receiving PATH benefits.

The lack of social support can contribute to increased HIV vulnerability and particularly with respect to marginalized populations. For instance, boys who exchange sex for money or goods are often homeless (Hutchinson et al 2007). Also there are limited opportunities for drug users to be rehabilitated and the only free rehabilitation centre which was run by the Salvation Army has closed. Female sex workers who used crack/cocaine were eight (8) times more likely to be HIV-positive (Duncan et al 2005).

Individual risk behaviour & reducing HIV vulnerability

In examining the broader determinants of HIV vulnerability it begs the question where is the individual responsibility, but in order to change behavior the context must be conducive to persons being interested in adopting and maintaining the behavior. Risky sexual practices, new partner acquisition, concurrency, partner selection, condom use, and even treatment are affected by Jamaica's inability to reach and sustain its human development goals. Therefore multilevel partnership and integration of measures to reduce social vulnerability into development programs remain critical.

Improving access to public health facilities and education through the removal of user and tuition fees was a major step in reducing household expenses in 2008. However, the need to increase social assistance programmes for those in need cannot be underscored. This thrust is echoed in Vision 2030 Jamaica – National Development Plan for Effective Social Protection, wherein the medium term priorities for the first 3 years are: strengthening of social assistance systems; effective targeting of vulnerable groups; and implementing adequate benefit schemes and levels, as well as expanding opportunities for sustainable livelihoods.

Behaviour change interventions focusing on condom promotion, STI treatment, partner reduction and HIV testing are all necessary. However, these programs cannot address the structural problems and the economic, social and cultural issues that contribute to HIV vulnerability and transmission. Sustained human development through multi-sectoral partnerships for social protection is essential for an effective response to the HIV epidemic.

3 VISION

To affirm and protect the rights of all Jamaicans including those infected with and affected by HIV and AIDS.

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

GOAL STATEMENT

To significantly reduce the number of persons newly HIV infected and mitigate the impact of HIV on the people of Jamaica through universal access to HIV prevention, treatment, and care; an effective multi-sectoral response and an enabling supportive environment free of stigma and discrimination.

OBJECTIVES

1. To reduce the number of new HIV infections by half by 2017
2. To achieve 95% coverage of ARV treatment for those eligible by 2017
3. To mitigate the impact of the HIV epidemic on persons living with HIV and on the country

GUIDING PRINCIPLES AND VALUES

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

Political Leadership and Commitment

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

Good Governance, Transparency and Accountability

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

Multisectoral Approach and Partnerships

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

Participation of PLWHIV

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

Equity

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

Promotion and Protection of Human Rights

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

Gender

The HIV program must promote gender equity and combat gender inequity and stereotyping of gender roles.

Evidence-based interventions

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

Participation of targets in design of programmes

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

Sustainability

The HIV program must be sustainable in the long term. This requires the integration of HIV strategies and activities into the regular policies, plans and programs of all sectors and communities.

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

Ten principles from the International Labour Organization (ILO) on HIV/AIDS in the world of work – recognition of HIV/AIDS as a workplace issue, non-discrimination, gender equality, healthy work environment, social dialogue, non-screening for purposes of exclusion from employment or work, confidentiality, continuation of employment relationship, prevention, care and support.

4 Enabling Environment and Human Rights

An enabling environment comprises a set of interrelated conditions such as legal, policy, bureaucratic, political, social and cultural which together reduce vulnerability to HIV and other diseases, promote a healthy responsible lifestyle and facilitate access to services in a sustained and effective manner. The Enabling Environment and Human Rights component of the National HIV/STI Program focuses on the development of laws and policies and supporting structures necessary to create an environment in which the risk of becoming HIV infected is reduced and persons living with and affected by HIV can access treatment, care and support services without fear of stigma or discrimination.

An enabling legal and policy framework is directly affected, being either supported or undermined by social, political and cultural factors. In Jamaica values and attitudes towards HIV, sex and sexuality are heavily though not exclusively shaped by religious, largely Christian mores. The strength and pervasiveness of these religious beliefs greatly influences policy makers and legislators. Therefore more efforts must be made to engage the faith based community at all levels in order to move the society as a whole towards more accepting and supportive attitudes towards persons living with HIV and their families as well as those most-at-risk of HIV.

Activities & Initiatives from 2007- 2012

During the 2007 to 2012 Strategic Plan period, activities of this component focussed on promoting the development and adoption of laws and policies to support the rights of persons living with HIV and activities to reduce stigma and discrimination.

Legislation and Policy:

1) Several pieces of legislation were examined. These included:

    - Public Health Act and Regulations- HIV and AIDS are designated as notifiable diseases and therefore communicable diseases within the Public Health Order. It was recommended that the communicable disease designation be for the sole purpose of surveillance and reporting and the provisions relating to communicable diseases set out in the Public Health Act and Regulations or the Education Act or any other Act or Regulation should not apply in regards to HIV and AIDS unless specifically stated to apply to these diseases.

    - Occupational Safety and Health Act- draft HIV regulations were developed to be appended to the Occupational Safety Act.

    - Venereal Diseases Act- Repeal of this legislation was recommended because it is outdated.

    - The Sexual Offences Act- it was recommended that criminalisation of the wilful transmission of HIV not be pursued due to the complexities surrounding definition and proof of wilful transmission.

2) The National HIV Related Discrimination Reporting and Redress System established in 2007 was strengthened and the investigative capacity improved.

3) Research for policy and legislative formulation:

- Focus groups were convened with faith-based leaders, parliamentarians, business leaders, entertainers and media practitioners to capture their views on four sensitive issues requiring legislative support for effective implementation.

- A situation analysis was undertaken as a precursor to formulation of policy to guide access to voluntary confidential counselling and testing by minors below the age of 16 years without parental consent,

Workplace:

The objectives of the workplace programme were education and sensitisation aimed at improving HIV awareness, reducing risk taking behaviour, promoting accepting attitudes and adoption of policies to protect employees from stigma & discrimination. Both private and public sector work sites were targeted through workplace technical officers assigned to various government ministries and private sector umbrella organisations including the Jamaica Business Council on HIV/AIDS, Jamaica Employers Federation, Jamaica Manufacturers Association and the Private Sector Organisation of Jamaica.

All government Ministries adopted HIV workplace policies and several ministries took steps to integrate HIV activities into their regular programmes. A range of materials to support the workplace programme were prepared including a comprehensive workplace instructional guide, best practice on HIV in the workplace, a mini discrimination survey and follow-up discrimination reduction conversation for the peer educators training programme.

Faith Based Organisation:

Under a project to build the faith based response to HIV participating churches revised their Sunday school curricula to include HIV issues and youth groups were empowered to deal with HIV through the performing arts. In depth interviews and focus group discussions were held with high level FBO leaders and stakeholders concerning those most at risk of HIV such as MSM and sex workers. The findings will inform capacity building and discrimination reduction interventions in the FBO setting.

Education of youth:

Two hundred youth leaders were trained as peer educators and a discrimination reduction tool kit was developed for use by youth leaders. The objective was to deliver youth-friendly HIV related stigma and discrimination education to youth leaders so as to create more accepting attitudes in relation to PLHIV.

Greater Involvement of Persons Living with HIV (GIPA):

In 2009 the GIPA Unit was created to assist in building the capacity and skills of persons living with HIV to contribute more effectively to the national response. Over 20 PLHIV have been trained for deployment in the workplace programme. Several JN Plus group leaders were trained to effectively manage the self-support groups and assist members with disclosure.

Achievements

- At the beginning of the Strategic Planning period 2007 -2012, 70 large private sector companies had participated in workplace sensitisation and training efforts, with 37 having adopted workplace policies on HIV. In 2011 over 220 large private sector companies had been reached through the HIV Workplace Programme and more than 160 had adopted workplace policies and/or action plans. All government ministries and agencies have adopted HIV workplace policies.

- Roll-out of the Voluntary Compliance Programme in the Ministry of Labour which includes audits of companies for compliance with the National HIV/AIDS Workplace Policy and in preparation for the passage of the Occupational Safety and Health Act and HIV Regulations

- Both Houses of Parliament approved the National HIV/AIDS Workplace Policy in 2010.

- Final HIV regulations based on the 10 ILO principles on HIV/AIDS and the world of work were drafted. These regulations will give legislative effect to the National HIV/AIDS Workplace Policy and will require private and public sector entities to adopt and implement HIV polices within the workplace.

- Registration of the Jamaica Business Council on HIV/AIDS (JaBCHA) and the establishment of the JaBCHA National Foundation in 2010. The Foundation which will take the lead in mobilising private sector resources to support the national response to HIV.

- A Multi sectoral Advisory Group was established to oversee the development and integration of the system to document and investigate reports of HIV related discrimination and effect redress.

- Prime Minister, Honourable Bruce Golding and Dr. Fenton Ferguson, on behalf of the Opposition, signed a commitment to HIV leadership advocacy on 30 November 2007. This commitment has bolstered the adoption of workplace policies within the private and public sector.

- Prime Minister, Honourable Bruce Golding and the Most Honourable Portia Simpson Miller, leader of the Opposition, signed a Declaration of Commitment to eliminate HIV related stigma and discrimination and gender inequality in Jamaica on 29 April 2011.

Challenges

The pace of legislative reform and policy adoption towards establishing an enabling environment is slow and the process is tedious. Too many parliamentarians and other persons of influence do not see HIV as a priority and many are uncomfortable with HIV related issues. The attitudes of Parliamentarians towards HIV related issues reflect, in part, the conservative views of most Jamaicans towards a range of sensitive social issues. Unfortunately, many of these views continue to fuel negative attitudes towards persons living with HIV and those most at risk including MSM and sex workers. These views create significant barriers to the education of our young people with safer sex skills, their access to prevention and reproductive health services as well as to treatment, care and support.

Resource constraints curtailed a number of important programmes including the training and deployment of youth leaders and peer educators, the development of champions for change and the pace of training PLHIV leaders.

The Way Forward

1) **To address stigma and discrimination towards Key Populations:**

a) Engage Faith Based Organisations in dialogue and build their capacity to participate more fully in the HIV response. Develop change agents and educators within FBOs and create a forum for sharing information and best practice.

b) Continue to sensitise and empower the police to address issues of stigma and discrimination against PLHIV and marginalised groups and to intervene appropriately in HIV and other related incidents.

2) **To increase the involvement of Persons Living with HIV in the national response:**

The participation of persons living with HIV in the national response makes a significant impact on peoples' perceptions by adding a human and personal dimension which often results in less stigmatising and more accepting attitudes. It is critical that persons living with HIV continue to participate in all aspects of the national response.

a) Train more PLHIV to address attitudes towards persons living with HIV and their families within different settings including workplace, faith based and community.

b) Adapt the positive prevention module on disclosure for use within the self support groups to enable persons living with HIV to disclose to partners, family and other persons.

c) In collaboration with JN Plus develop a programme for family and friends of PLHIV to promote more accepting and supportive attitudes towards persons living with HIV.

3) **To address Stigma and Discrimination within the Health Sector**:

There are far too many reports of discrimination within the health sector. Many of the complaints concern the lack, or perceived lack, of confidentiality. This often hinders persons from accessing HIV testing and treatment. The following activities are proposed to address this problem:

a) Amend legislation that governs health professionals and other health staff to specifically include the requirement for patient confidentiality and enforce disciplinary action for breaches.

b) To require health institutions to conduct ongoing orientation, sensitisation and training in medical ethics, stigma and discrimination and other HIV related matters.

c) Examine the policies and practices across the health sector to determine if and how these may undermine patient confidentiality with a view to addressing gaps and adjusting structures and procedures to maintain and strengthen confidentiality.

4) **To improve accountability to Human Rights Standard in relation to HIV**

a) Integrate National HIV related Discrimination Reporting and Redress System (NHDRRS) into existing disciplinary mechanisms through cabinet approval

b) Expand redress partners to include FBOs, selected PLHIV, family and friends and Benevolent Societies

5) **To address issues related to access to prevention treatment and care services by youth**

a) Examine legislation and policy that affects access of youth to prevention, treatment and care services such as Child Care and Protection Act, which is legislatively due for review

b) Through the MOE roll out training of Youth Leaders using S&D manual previously developed

6) **To sustain the HIV policy development and implementation within the workplace setting**

a) Promote and support efforts to accelerate the passage of the Occupational Safety and Health Act and the HIV regulations

b) Collaborate and provide technical support to Ministry of Labour and Social Security, the Jamaica Business Council on HIV/AIDS and other stakeholders.

5 Prevention

HIV prevention in the previous National Strategic Plan focused on increasing interventions for the most vulnerable populations while maintaining high levels of HIV awareness among the general population. The shift to scaling up targeted prevention interventions reflects the evolutionary nature of the prevention programme in keeping with the dynamic nature of the HIV epidemic and the application of international best practice. The National HIV/STI Program has embraced the concept of combination prevention which involves a synergy of behavioural, biomedical and ARV/STI treatment approaches as well as measures to promote social justice and human rights. The prevention response must be comprehensive, holistic, focused and adaptable in order to be effective.

The revised behaviour change communication (BCC) strategy provided the framework for the prevention interventions in keeping with the following principles:

Focus on the most vulnerable populations: these are persons who are at an increased risk of HIV due to their social circumstances and unsafe sexual behaviours. These persons include:

1. **Men who have sex with men:** HIV prevalence among MSM is 32%. Unprotected anal intercourse is a major risk factor for HIV infection. Condom use among MSM is inconsistent and multiple sexual contacts common. 54% reported more than two male sex partners in the past 12 months, while 34% reported two or more female partners in the past 12 months. 29% reported having sex in the past four weeks without a condom (Figueroa 2011). There is great diversity among MSM in terms of age, education, income. social status, sexual practices, sexual networks, level of disclosure and vulnerability to HIV infection. There are also male sex workers who solicit male clients from street sites and clubs.

2. **Female sex workers:** HIV prevalence among SW is 5% or higher. Condom use with paying clients tends to be high (97%) However, condom use with non paying partners is low (23%). 56% of SW had at least one STI indicating unprotected sex. Alcohol use is common and 35% use ecstasy (Duncan 2010). Female sex workers work in different settings, are often quite mobile, may be seasonal and may not self-identify as a sex worker although they receive money for sex on a regular basis.

3. **In school youths:** Early initiation of sex continues to be a concern; the median age for first sex is 13.5 years for girls and 15 years for boys. Much of the sex among teens is opportunistic. Condom use tends to be low and some teens have multiple sex partners. Girls are at higher risk of HIV infection due to sex with male partners who are 10 or more years older, participation in transactional sex and frequently being forced to have sex.

4. **Out of school/unattached youths:** There are an estimated 250,000 (STATIN 2009) unattached or out of school youths 15 -24 years. Many engage in risky sexual behaviours including unprotected sex and transactional sex. Some street boys or homeless youths engage in MSM sex work. These youths are highly mobile, have limited social, community or familial networks to provide support and tend to be dependent on their peers.

5. **Inmates:** HIV prevalence among prison inmates is 3%. While the correctional facilities are regarded as no sex zones, it is imperative to provide prevention and treatment services.

6. **Homeless drug users:** HIV prevalence among homeless drug users in Kingston is 7%. Some of these persons are sex workers who use crack cocaine. Condom use is low.

7. **Low income communities**: In some low income communities adults 19-39 years of age engage in multiple partnership and transactional sex with inconsistent condom use. Some of these males may be involved in illegal activities and have cash to spend on women over whom they wield power and make it difficult for her to practice safe sex.

8. **STI clinic attendees:** By definition these persons are at higher risk of HIV infection. Some of the men are clients of sex workers, many have multiple sex partners.

Within all these populations there are sub groups that can be regarded as being at highest risk owing to their low income and limited access to social services. These socially marginalised persons are likely to engage in risky sexual behaviours in order to survive.

Prevention for positives: As the life expectancy of PLHIV increases with the availability of ART there is a need to ensure that the quality of life for these individuals is optimized while avoiding HIV transmission to their sexual partners.

Addressing social vulnerability: Structured, sustainable policies, strategies and programmes are needed to reduce social vulnerability.

Gender: Gender inequality and socially ascribed gender roles and behaviours contribute to increased vulnerability and risk to HIV for both women and men in Jamaica. Gender inequality and stereotypes affect the ability of men and boys, women and girls to access HIV, health and social services.

Evidence based: Prevention programs must be designed and implemented on the basis of evidence and best practice. The findings and lessons of the PLACE surveys and other research conducted in Jamaica informed the scaling up of interventions.

Key sectors partnerships: Partnerships that have been forged with the Ministries of Education, National Security, Labour and Tourism and other governmental agencies as well as a wide range of organisations and stakeholders including various private sector and NGOs must be maintained and strengthened.

Civil Society involvement: A wide range of civil society organisations and stakeholders have been involved in the prevention response despite challenges of limited technical capacity and resources and sustainability of programmes. Some NGOs have provided access to persons most at risk who are hard to reach. Involvement of civil society must continue to expand and be strengthened.

BCC skills building: The shift from an emphasis on providing information on HIV to engaging the most at risk populations in risk reduction conversations reinforced the need for building behaviour change communication skills within the national programme and its partners. This involved the standardization of approaches and improved monitoring for quality of interventions as well as initiatives to develop a minimum package of services for key populations.

Reaching general population: All Jamaicans must know how to reduce their risk of HIV infection. This has been approached through the use of mass media, educational materials, special events and cultural activities. These interventions will continue in order to shift, reinforce or create new social and cultural norms that reduce HIV vulnerability and risk.

A**chievements:**

- **Interventions with MARPs:**
    - Scale up of interventions to the MSM population has resulted in 15,943 MSM being reached through site based prevention interventions. A total of 453 MSM have been tested for HIV while 567 have been trained as peer educators.
    - 24,768 sex workers have been reached through the prevention activities conducted at sex sites or within workshop settings. A total of 2675 sex workers have been tested for HIV while 1380 have been trained as peer educators.
    - All 250 prevention team members in the Regional Health Authorities (RHAs) have been trained in the standardized prevention strategy to reach the key populations including MSM, sex workers, out of school youths and others.
    - Three (3) additional NGOs; Children First, Jamaica Red Cross and Pride in Action have been supported in the national response to reach MSM. These NGOS have adopted the standardised MSM strategy and conducted the interventions. Prior to 2007 only one NGO JASL was conducting MSM interventions.
    - 35,088 adolescents and 111,813 youths have been reached with prevention activities conducted by Regional Health Authorities, Child Development Agency and NGOs including Hope Worldwide, Children First and Jamaica Red Cross in out of school settings. Interventions included risk reduction education, HIV outreach testing, condom skills and access, income generating activities and skills, and education grants.
    - Approximately 53% of the total population 2,519 inmates have been reached for HIV testing and prevention activities. These interventions have now been institutionalized in one major adult correctional facility and facilitated periodically at three other facilities.
    - HIV outreach testing has been conducted with the homeless and drug users as part of an initiative being spearheaded by the National Council for Drug Abuse since 2009.
- 1,069 condom outlets were established in non traditional locations, including community shops, bars, clubs, and itinerant vendors by the prevention teams in the Regional Health Authorities.
- 87% of schools have implemented the revised Health and Family Life Education curriculum reaching 418,517 students. A baseline survey has been conducted and impact evaluation will be conducted in 2012.

- 60,202 persons have been reached for HIV outreach testing as a result of the introduction of rapid test kits and the acquisition of two mobile testing buses.

- Six new media campaigns were developed based on evidence from the2008 KAPB and other surveys to support the targeted interpersonal strategies of the BCC outreach teams. Media recall surveys were conducted for all campaigns. Two of these campaigns had extremely high message recall; "Pinch, leave an inch and roll" had 85% prompted recall while anti-stigma and discrimination had 84% prompted recall. Of the two outstanding campaigns one promoted condom skills for young people and the other introduced two new PLHIV; Jason Richards and Rosie Stone and encouraged persons to support PLHIV. The other campaigns addressed the critical issues of women initiating condom use, HIV testing, communicating with children about sexual issues, and reduction of multiple partnerships.

- Twenty five (25) civil society organizations are now involved in the national response. This is a significant increase from three (3) in 2006. The civil society partners are conducting interventions among youths, MSM and sex workers.

- Introduction of 4 Regional PLHIV liaison officers to implement the prevention for positives strategy has resulted in establishing 36 support groups for PLHIV since 2010. One is a support group for HIV positive MSM.

- Intervention in line ministries as part of the multi-sectoral response has become more targeted. The Ministry of Labour has institutionalized routine HIV screening and risk reduction activities for migrant labourers while Ministry of Tourism has implemented outreach HIV testing for their most at risk workers, that is those who are most likely to be involved in sex tourism.

Challenges:

Despite the scale up in interventions to reach the most at risk populations, it is estimated that only 30% of these populations are being reached. Many MSM, clients of sex workers and discrete sex workers who operate in massage parlours or through the internet or telephone are not being reached. There are also many persons within lower income high prevalence communities, including unattached youths and persons engaged in transactional sex, who are not being reached due to poverty, violence or other factors. Some of these individuals shun engagement with the formal system. There is a need to increase coverage for these key populations with high quality, standardized and sustainable interventions.

HIV testing among those most at risk population and among men is lagging despite the increase in outreach testing. There is the need for increased capacity to conduct provider initiated HIV testing at health facilities and other sites.

The Health and Family Life Education programme needs to be strengthened. Implementation remains ad hoc in many schools and the Ministry of Education lacks capacity to adequately monitor the programme. The Ministry of Educations will have to develop a strategy to ensure effective implementation and

monitoring of this curriculum. Students who are sexually active are not being addressed as there is no policy or mechanism to support a meaningful response.

More civil society organisations are involved in prevention or show the interest and commitment. However, they continue to be hampered by limited technical, financial and human capacity. Although some of these organizations have worked in HIV prevention for decades they have been unable to scale up coverage due to limited resources and over dependence on a single source of funding.

There has been insufficient ownership of the HIV response by critical government sectors. Involvement has often been limited to HIV education for staff. There have been few policy initiatives within sectors which have resulted in a more supportive environment for sustaining safer sexual behaviours.

The Way Forward

Reaching key populations
Expand interventions to reach the key populations most at risk of HIIV:

a. **Men who have sex with men:** there needs to be increased HIV testing among this population. The NHP and its partners intervening with the population have to be equipped to normalize HIV testing. MSM will be provided with rapid HIV and syphilis testing as central components of interventions. HIV positive MSM will be referred to MSM friendly health care providers at public health facilities for treatment care and support.

   Specific approaches will be developed to reach sub groups of MSM: sex workers, adolescent MSM, PLHIV, bisexuals in upper social classes as well as other MSM with money, power and influence who are usually the decision makers in the sexual relationship. Many of these MSM are not easily accessible. In response to this challenge interventions utilizing technology will be implemented, including use of social media, websites, chat rooms and text messaging. This technology is widely used by the population across the social classes.

   Interventions will also seek to improve access to services, hence the need for training health care providers to provide MSM friendly services.

   Strategies will be developed to reduce social vulnerability and promote social inclusion for those without social support. This will include access to literacy training, education and income generating skills and grants. The families of homeless MSM will be approached to re-integrate their relative. Where this is not an option, linkages will be made with civil society or social agencies to provide shelter.

   Risk assessment and condom negotiation skills have to be strengthened in this key population. They will also be given increased access to lubricants. Prevention messages will be specially designed and disseminated including use of information communication technology.

b. **Female Sex workers;** given the highly mobile nature of female sex workers mapping of sex work sites will be done and targeted interventions designed for the SW and patrons at these sites. This will increase the reach of prevention services. Low condom use by SW with their regular

partner and regular clients as well as accessing sex workers operating in massage parlours remain as critical challenges to be addressed.

Lessons from working with SW indicate that repeat interventions with the population assist in reinforcing the desired behaviours. While this approach will continue, there will be an increased focus on reaching partners and clients of sex workers to improve risk perception and condom use. Outreach HIV and syphilis testing at sex work sites using rapid tests will be increased with referral for treatment and care where indicated.

Strategies to address social vulnerability will also be implemented therefore sex workers will be facilitated to access education and income generating grants as well as other services that will provide social support for their children.

Male sex workers intervention with this sub population has been limited as this is a hard to reach group which tends to operate in discrete locations mostly in the tourist sites. It is important that some research be done with this population to determine the profile andt he risk behaviours prior to the development of interventions.

c. **Out of school youths;** homeless, out of school youths and street youths who engage in MSM activity will be the main focus for the period of the plan. These youths are mainly males 15 -24 years of age who are likely to engage in unprotected transactional sex with several male partners. This population requires structural intervention, to reduce their vulnerability. A comprehensive response will have to provide access to shelter, opportunities for reintegration into families, literacy skills, income earning skills and the provision of basic tools for social inclusion for example; birth certificates.

Risk reduction behaviours of seeking treatment for STI, partner reduction, consistent condom use and condom negotiation skills need to be integrated into the structural interventions which are intended to empower the individual to practice the desired healthy behaviour.

It is necessary to institutionalize the social inclusion strategies for this and other key populations through the formation of strategic partnerships with other sectors to address social support for key population which have been marginalized and require a coordinated effort to address the social determinants of unsafe sexual practices.

d. **In school adolescents:** the Ministry of Education has been implementing the Health and family life education curriculum to in school youths aged 10-15 years. It is imperative that adolescents be equipped with the skills to negotiate the challenges of early sexual activity and be prepared for healthy sexual and reproductive lifestyles.

An important objective for this period is to assess the quality of life skills education being provided for students.

The Ministry of Education is responsible for institutionalising and sustaining HFLE in the schools from early childhood to secondary level. Towards this end the monitoring of the quality of implementation must be improved and the in-service and pre-service training of specialist teachers who facilitate the integration of HFLE as a core curriculum subject must be maintained.

The HFLE policy which has been developed should be implemented to provide the supportive environment for the HFLE curriculum.

There is a need to implement the HFLE curriculum in early childhood institutions. The curriculum has been developed and a small pilot conducted, it is expected that this should be scaled up and evaluated over the next five years.

The Ministry of Education also needs to strengthen existing parenting initiatives and explore how to institutionalise parenting interventions within its role of providing comprehensive quality education for its beneficiaries.

e. **Homeless drug users:** intervention among homeless drug users will be scaled up and include a strategy for rehabilitation including reintegration with families.

Prevention for positives; interventions will be expanded to reach more PLHIV. The positive prevention strategy was developed to address the specific needs of PLHIV in the context of the family, the community and the health care setting. Implementation has been limited. An evaluation will be conducted to determine the challenges of implementation and corrective action taken.

Social support for the PLHIV and those affected will be improved and the health care team will be trained in positive prevention in order to improve care and support within the health setting. At the community level interventions will address issues relating to stigma and discrimination in order to create a more supportive environment for PLHIV. At the individual level, counsellors will facilitate PLHIV to disclosure their status to relatives or friends.

Increasing access to condoms for key populations; condoms must be available at sites frequented by the key populations including adolescents. Establishing non traditional condom outlets in communities and popular hangout spots will be continued. The strategy will focus on partnerships with private condom marketing companies establishing condom outlets at sites identified by the PLACE (Priority for Local AIDS Control Efforts) method and also known sex work sites. The condom marketing companies will be challenged to be responsible for establishing and maintaining these outlets. This approach will address sustainability of condom supplies to key populations and reduce dependence on free condoms from the public sector. Free condoms will be distributed on a more limited scale.

Gender: A deliberate strategy to expand prevention interventions targeting MARPS to address gender based violence, sexual assault and sex tourism. This response is critical given the vulnerability of women and girls, the high unemployment rates, the high number of female headed households and the prevalence of violence against women. The response will continue to develop a cadre of behaviour change specialist trained in Gender, particularly how the gender imbalance impacts HIV prevention. This team will be responsible to facilitate training of the health care providers and civil society partners to address the gender issues within the contextual factors affecting risk behaviours of males and females. The gender based interventions will seek to increase opportunities for heterosexual males to be reached to encourage dialogue on risk behaviours particularly multiple partners.

Civil society has been recognized as critical partners in scaling up HIV prevention. However, this has not yet yielded results in Jamaica. The profile of civil society organizations that can be involved in the national response will be reviewed. The larger established organizations which have a comparative

advantage in areas of social support such as housing, skill development, income generating activities, educational grants and psychosocial support will be targeted.

Evaluation of interventions: The 2008 KAPB indicated that there has been no significant reduction in some of the risk behaviours relating to HIV transmission such as transactional sex, multiple partnerships and condom use. There are several structural factors contributing to these behaviours. While there have been some initiatives to implement structural interventions, for example empowerment workshops, the impact of these interventions is uncertain. Prevention interventions have to be evaluated to determine impact prior to scale up. A number of interventions are in the pilot phase and their evaluation is critical for refining or discarding the strategies especially those addressing the key populations and the drivers of the epidemic.

Ministry of Tourism; expand interventions to reach persons in the sector involved in sex tourism. There is the need to secure commitment from sector leaders to institutionalize HIV prevention education for employees and to increase access to condoms for both workers and guests. Increased access to condoms should be regarded as integral to sustaining the tourism product.

Media and popular culture: the use of several types of media to create, reinforce and sustain particular social norms relevant to safer sexual behaviours will continue as an important strategy. The strategy will use social media to reach the key populations including; youths, MSM and sex workers. Media campaigns will be developed to generate public discussion on specific risk behaviours which have not been confronted on the public agenda including anal sex, intergenerational sex, transactional sex, multiple partnerships and gender.

The media alliance will be revitalized to increase the involvement of new media and traditional media houses to infuse the popular culture with HIV related issues utilizing cultural icons and new technology.

6 Treatment, Care and Support

Treatment, care and support services require an extensive system that facilitates access to HIV testing and counselling, diagnostic services, specialized clinical care, antiretroviral medications, psychological and social support. This system has been implemented in Jamaica and has positively impacted the lives of PLHIV. In spite of the successes of the treatment component of the programme there are major challenges to providing adequate access to health services. These challenges include the high proportion of persons living with HIV who do not know their HIV status, do not access treatment, access care at a late stage of disease progression or do not adhere to their antiretroviral medication. Also important is the quality of treatment and care and the ready access to a steady supply of ARV drugs on a sustainable basis. Other challenges include continued stigma and discrimination that hinder many persons from getting HIV tested, seeking treatment or disclosing their HIV status to their families or sex partners as well as a shortage of health and social service providers and weaknesses in the health system itself.

1. Achievements

Screening and Diagnostic Services

- Over 1,130,000 HIV tests have been performed over the past 5 years
- Approximately 23,000 CD4, 7,000 Viral Load and 1,300 DNA-PCR tests were conducted during 2009 and 2010
- Currently, DNA-PCR, CD4 and viral load testing are available free of cost
- HIV testing and counselling is available at all major health centres with nearly all of the relevant staff (Contact Investigators, Social Workers, Public Health Nurses) trained in the VCT protocol.
- HIV rapid testing is operational in most peripheral clinics allowing same day results in some instances.
- Provider initiated HIV testing and counselling (PITC) has been introduced at all hospitals.
- HIV testing is decentralized with each region having the ability to carry out HIV screening and confirmatory testing without having to send samples centrally to the National Public Health Laboratory (NPHL).
- CD4 testing facilities have been established in Kingston at the National Public Health Laboratory and in St. James at the Cornwall Regional Hospital. On site CD4 testing has being piloted at three (3) treatment sites and is slated for roll-out to selected treatment sites.
- Viral load testing has been established at the National Public Health Laboratory.
- DNA-PCR testing is provided for infants of HIV positive mothers allowing for early diagnosis and treatment of paediatric HIV/AIDS.

Medical Management

- There has been a significant decline in the number of persons reported with AIDS and deaths due to AIDS since the introduction of ARV treatment. The survival and quality of life of persons living with HIV has improved dramatically.
- More than 8,000 adults and children are on ART in accordance with national guidelines (2010).
- Twenty-three (23) treatment sites (paediatric and adult) were established across the island with a trained team of providers in each facility
- Guidelines for the clinical management of HIV and AIDS were revised
- HIV management has been integrated into the primary health care system
- Several training programmes have been conducted for all categories of health staff in the clinical management of HIV/AIDS.
- The Annual HIV Clinical Management Workshop has been institutionalised through the Caribbean HIV/AIDS Regional Training Network (CHART).
- Relevant health staff have been trained in the management of STI and Opportunistic Infections.
- There is a partnership with selected private physicians to facilitate the treatment of PLHIV in the private setting.
- The manual on the nutritional management of HIV/AIDS developed by the Caribbean Food and Nutritional Institute (CFNI) and the Canadian International Development Agency (CIDA) was used for ongoing training

Prevention of Mother-to-Child Transmission (PMTCT)

- Mother to child transmission of HIV has been < 5% since 2007.
- HIV screening is available for pregnant women who present for care. In 2010 >95% of public sector antenatal clinic attendees were screened (20,000 compared to 4,000 in 2002). Most pregnant women in the private sector are also screened.
- Antiretroviral (ARV) treatment (triple therapy) for the Prevention of Mother-To-Child Transmission (PMTCT) was provided to 87% of HIV-infected pregnant women in 2010 and 98% of HIV-exposed infants (Zidovudine/Nevirapine).

Post-Exposure Prophylaxis

- A training manual is in use and antiretroviral drugs were available in all regions for the prevention of HIV transmission to health workers who were accidentally exposed at work.

2. Challenges

Sustainability: Treatment, care and support is funded for the most part by international grants. Antiretroviral drugs, HIV testing supplies, supplies for laboratory monitoring of PLHIV and many health staff (social workers, adherence counsellors) are grant funded. As funding declines, the financial support for these critical inputs has not been clearly identified.

Staff shortage: There is a severe shortage of human resources in the field and this may be one of the greatest limitations to programme success. The lack of adequate numbers of Medical Officers of Health to manage the HIV and other vital health programmes as well as the general shortages of doctors, nurses, social workers and counsellors limits the programme's reach. The lack of pharmacists is a critical gap that results in extended waiting times at pharmacies. This sometimes results in repeated trips to pharmacies and to suboptimal ARV adherence. The lack of routine testing throughout the health system, limited integration with existing health and family planning services, and inconsistent implementation and monitoring of the policies and plans are in part due to this shortage.

HIV Testing: Approximately 15,000 persons who are HIV infected do not know their status. This represents just under half of the estimated total number of infected individuals in Jamaica. Males and young people 15-24 years old are less likely to be tested than females and those aged 25-49 years. Only 10% of hospital admissions are being tested for HIV, and even smaller percentages from Family Planning and other regular clinics. Many persons most at risk of HIV are not being HIV tested including 50% of public STI clinic attendees.

Treatment: The treatment programme has well exceeded the former NSP's target of reaching approximately 6,000 by the year 2012. However, an estimated additional 6,000 persons are still in need of ART. 40% of HIV infected persons are diagnosed when they are symptomatic and 14% are diagnosed as AIDS or as an AIDS death (2008). Inadequate adherence to ARV medication by many PLHIV is a major challenge and negatively impacts the success of the treatment and prevention programmes. Inappropriate sequencing of ARV drugs for treatment by some physicians also needs to be addressed.

ARV Supplies Management: In spite of free access to ARV drugs, there are considerable challenges along the supply continuum which affect patient care. Only a limited number of pharmacies stock ARV drugs requiring many patients to travel far distances and wait long hours for their medication. Poor management systems at the central warehouse and the severe shortage of pharmacists in the public sector negatively affect the timely distribution of ARV drugs to pharmacies. This results in regular stock outs of ARV drugs. These problems seriously undermine patient care by contributing to poor adherence to ARV therapy, increasing the emergence of HIV resistance to medication and reducing the length of time on initial ARV regimens. This will result in patients failing treatment earlier, reduced patient survival times and increased treatment costs.

Diagnostic Services and Laboratory Capacity: Although the laboratory has played a significant role in the programme, the structure and management of the existing lab services still needs significant improvement. Access to viral load and CD4 testing is very variable for several reasons including poor

inventory management of reagents and other supplies, staff shortages and chronic transport problems. The latter problem adversely affects CD4 testing because the sample is fragile and requires processing within 24 hours. Non-adherence to laboratory monitoring guidelines also results in sub-optimal patient care. ARV resistance surveillance is not yet established.

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

Tuberculosis (TB) Screening: The screening of PLHIV for TB has been limited and is difficult to monitor. Follow up of TB contacts and patients completing therapy in the community is inadequate. Diagnostic capacity for TB remains limited and centralized with limited surveillance for multi drug resistant TB.

3. The Way Forward

The purpose of the treatment, care and support component is to achieve universal access to high quality comprehensive treatment, care and support in an environment that is non-discriminatory and supports adherence. The gains that Jamaica has made need to be sustained while increasing coverage of those in need of ARV treatment and addressing the challenges in a way that strengthens the health service as a whole. Priories for the 2011-2015 period in treatment, care and support include:

HIV Testing: Testing of those most at risk, such as MSM, sex workers and homeless persons, will be scaled up. Civil society, peer counsellors and outreach workers have an important part to play in identifying and offering HIV testing and counselling to those most at risk. These partners must be trained, provided with logistical and technical support and monitored for quality assurance. Provider initiated testing will be strengthened with the aim to test all hospital admissions and testing persons who present to larger/urban Accident and Emergency Departments with a focus on trauma cases (KPH, STH, UHWI, CRH, SPGH, SABH, MPH, MRH). Testing of STI patients will be improved. Private care providers will be re-sensitized about the need to routinely offer an HIV test to their patients especially their STI cases. HIV testing and counselling will be expanded to all prisons and selected health centres in high risk communities. Partnerships with media entities will be strengthened in order to raise public awareness regarding the importance of testing. Self testing methodologies will be explored and recommendations made to the public accordingly.

ART Treatment: Universal access to ART must be achieved. Access to HIV treatment and care must be further decentralized and integrated within existing health services while maintaining referral to HIV specialist centres for expert follow up. HIV Treatment protocols will be updated in keeping with international best practice and local conditions.

Strengthening the treatment services system within the Health Regions is critical to improving public access to quality treatment and care services for PLHIV. Because there is a severe lack of staff to adequately support ARV treatment in the Health Regions, absorption of project-funded treatment, care and support staff by the general health care system is a priority.

Additional access points for ARV drugs will be provided at private pharmacies and patients who are adherent will be dispensed ARV supplies for up to 3 months at a time. Further integration of treatment and care services within the general health care system will contribute to the sustainability of the programme.

Treatment for Prevention: HIV prevalence rates among MSM combined with the high risk of transmission associated with unprotected anal sex support the implementation of ARV treatment for prevention among the PLHIV MSM population. ART will be initiated early following HIV diagnosis for MSM after an assessment of their readiness for treatment and intensive adherence training. Augmented adherence support will be provided. This approach will be monitored carefully and assessed.

Adherence: Strategies to promote adherence to ARVs and care will be a major focus in this strategic plan. Health providers will participate in a meaningful way to promote adherence, through:

- Implementation of a structured adherence counselling protocol for pre ARV treatment
- Strengthening of treatment support groups.
- Referrals for Mental Health services as indicated
- Amending the terms of reference of adherence counsellors to include counselling for other common chronic diseases along with counselling for HIV testing.
- Enrolling persons on ARVs with NHF. This will facilitate continued access to medication and improve the monitoring of ARV adherence and the number of patients on ARVs.

Social Support for PLHIV on ARV therapy who are most in need: Reducing social vulnerability by increasing access to economic opportunities and jobs is important in building self-efficacy, reducing risk and promoting adherence to ARVs. This will be achieved through partnerships with civil society, the private sector, NGOs and other sector ministries and agencies.

Positive Prevention: Positive prevention programmes will be scaled up and implemented at all HIV Treatment centres and will do the following:

- Train treatment teams in Positive Prevention (inclusive of behaviour change) methodologies.
- Develop support groups and intervention counselling for PLHIV attending treatment sites

PMTCT: In keeping with international standards, the PMTCT programme will focus on prevention of unintended pregnancies among women living with HIV, prevention of HIV transmission from women living with HIV to their children and provision of treatment, care and support for women living with HIV and their children and families. Specific activities aimed at scaling up this response are:

- Re-sensitizing health providers to the updated manual for the PMTCT of HIV and Syphilis
- Piloting the implementation of the positive prevention strategy among women and men with reproductive capacity

Diagnostic capacity: Focus will be placed on building the capacity of the regional laboratories and selected treatment sites to offer CD4 testing. Efforts at the TB lab will be continued to improve access to appropriate methodologies for culture of TB. Also, the capacity for resistance testing for Anti TB and HIV drugs will be explored with a view to providing resistance testing in appropriate settings as well as to allow for HIVDR surveillance.

Tuberculosis: Linkages between TB and HIV programmes will be strengthened with the aim of improving screening of PLHIV for TB and ensuring facilities for early diagnosis and drug resistance testing.

Sexually Transmitted Infections. Jamaica has achieved considerable success in reducing syphilis and other STIs through the decentralisation of syphilis testing, syndromic management of STIs and other measures. However, other STIs remain a significant problem. The position of Senior Medical Officer (Health) for STIs needs to be re-established so that there is ongoing specialist leadership of the STI program in Jamaica.

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

- Updating the infection control manual as indicated, with widespread distribution and training
- On-going training of health workers in the management of post exposure prophylaxis.
- Continuation of the technology for medical waste (including sharps) management

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

Training: In collaboration with CHART specific short courses for HIV management, STI treatment, PMTCT, Positive Prevention, Stigma and Discrimination, Adherence, Infection Control and Counselling will be provided for health staff. This will aid in ensuring standardization and quality of care.

Inclusion of HIV training in medical training curricula: Compulsory HIV modules including for the care of the PLHIV must be developed and integrated in undergraduate and post graduate training of clinicians.

Stigma and Discrimination: Ongoing attention to reducing stigma and discrimination in the health care setting will include training of staff, review of procedures to ensure confidentiality, customer relations and disciplinary measures where acts of discrimination and breaches of confidentiality are identified.

STRUCTURE

Monitoring and Evaluation continues to be a programmatic priority in the national HIV response and the national M&E system must complement, monitor and evaluate the interventions outlined in this strategic plan. The Jamaica National HIV Monitoring & Evaluation System is organized around the twelve essential components of a functional M&E systems (UNAIDS, date). These 12 components all need to be present and work to an acceptable standard for the national M&E system to function effectively. All components of this system have been established to varying degrees during previous strategic

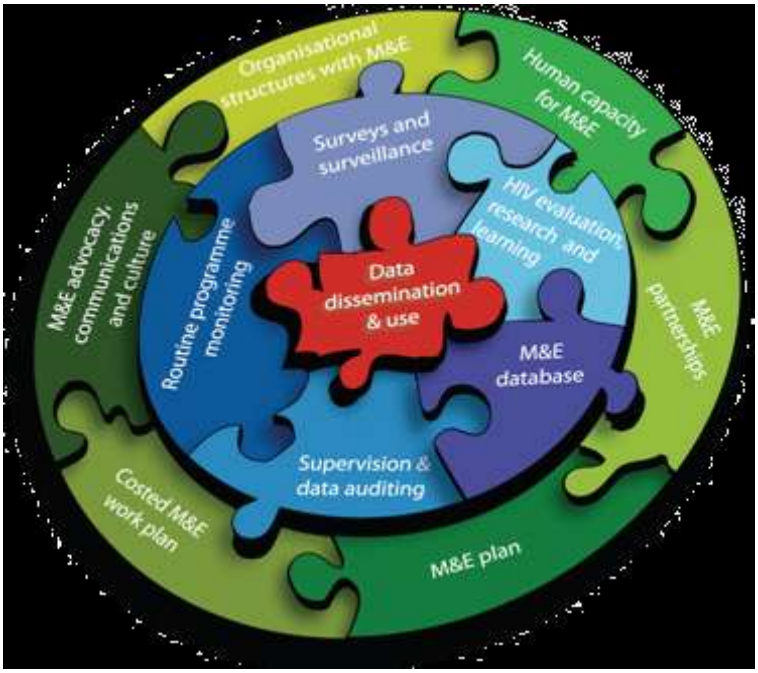


Figure X—Organizing framework for a functional national HIV M&E system:

planning periods. Each of the components of the national HIV M&E system, the accompanying performance goal and associated performance results are described in the national HIV M&E Plan (Document B).

DATA FLOW

The Monitoring and Evaluation (M&E) system consists of various inter-related components (FIGURE #), 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 disseminated 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.

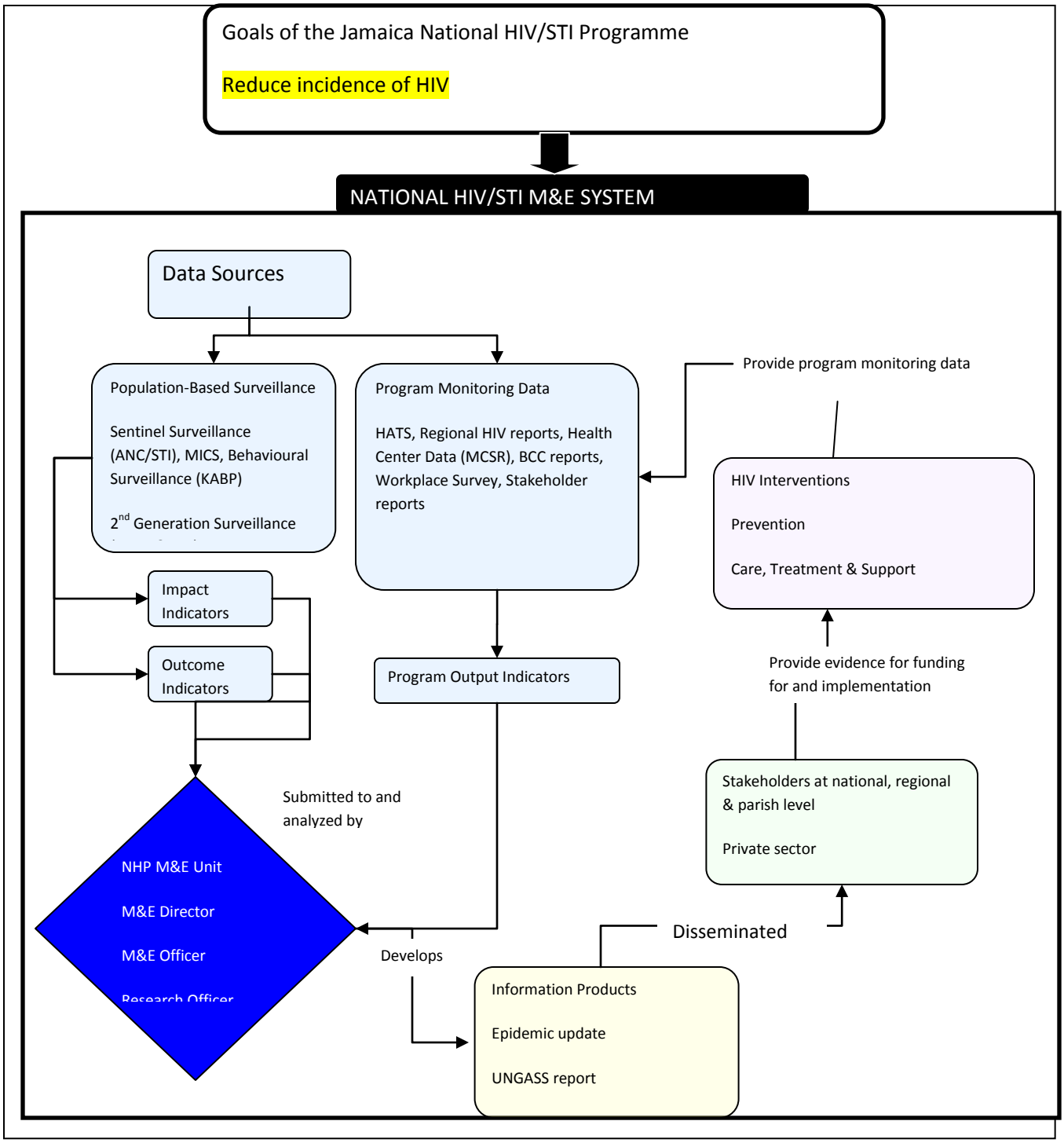


Figure #: Summary of the Jamaica M&E system

ACHIEVEMENTS

Some activities carried out under this component in the previous strategic plans included the development of a national M&E plan and operations manual, training of stakeholders in basic and advanced M&E concepts, development of databases, standardization of data collection tools, and development of a research agenda. More specifically, some of the actions taken to strengthen the M&E system in the 2007 – 2012 strategic planning period included:

- Standardization of reporting tools and ongoing refinement and modifications to improve reliability and accuracy of data.
- The development of the M&E operations manual to detail all the core indicators of the national response. The manual also addresses issues related to data flow, data quality and data use
- Shift from paper based to computerized data management. Development of a M&E database to capture stakeholder data and allow for easy processing of M&E reports.
- Development of the electronic ARV database and rapid test database to capture new variables and generate new reports on early warning indicators. The ARV database also facilitates the monitoring of clinical parameters important to tracking treatment success.
- Capacity building among all stakeholder in M&E through training workshops and provision and use of technical assistance
- Implementation of strategies for dissemination of information garnered from the M&E system. M&E has played 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.
- The National MERG has been revitalized, a TOR drafted, and a network of M&E personnel established. The MERG played a key role in refining the M&E system, finalizing the M&E plan, and have been important in gaining consensus on data gathered for international reporting needs.
- Monitoring responsibilities are integrated into Terms of Reference and Memoranda of Understanding with stakeholders.
- Increased operational research, including implementation of a national HIV research agenda through the MERG to answer key questions for programme management. Completed research includes two MSM surveys, which gave insight to the behaviours that enable HIV transmission and confirmed the estimated high HIV prevalence in this key target group. Surveys have also been conducted among sex workers and homeless persons in the Kingston metropolitan area. Completed evaluations include an assessment of the Adherence Programme and the Workplace Programme and a evaluation of the impact of outreach testing events. Other special studies have included a study to determine the genetic diversity of HIV in Jamaica and a qualitative study among MSM that gave insight into findings from the quantitative second generation surveillance exercise.

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

CHALLENGES

Stakeholder Capacity

Despite many advances, further development of the M&E system has been hindered by the limited

capacity of some stakeholders to implement the M&E plan and research agenda. Implementing stakeholders often lack the capacity to conduct appropriate surveillance or evaluations and to use available data for decision-making. Very few stakeholders have a committed M&E position, and even fewer have developed M&E plans for their programmes.

Databases

Many of the databases that have been developed are being used at a sub-optimal level, thereby limiting their usefulness and accuracy. An additional challenge with the development of the M&E databases for monitoring data, is that they are stand alone databases that are not currently linked or merged. The proliferation of multiple, unlinked databases in the M&E system is partly due to databases being developed in response to international demand for specific indicators. The goal is to have an integrated Monitoring and Evaluation information system, however a number of technical and resource challenges have slowed the process of merging these databases.

Data collection and management

Disaggregated data on some key indicators are still unavailable, limiting the understanding of access to services by key populations, men and women, as well as boys and girls. Furthermore, the need to determine outcome and impact after 5 or more years of scaling up of interventions such as outreach education, HIV testing and treatment has become urgent in order to inform future strategies. The gaps in collecting data from the private healthcare practitioners remain. The data management capacity of the Monitoring and Evaluation Unit requires additional support to meet the demands associated with the increase in incoming monitoring data. The unit must also demonstrate capacity to process the data efficiently and provide feedback to stakeholders.

Data Dissemination

M&E data becomes most useful when it increases our understanding of the epidemic and informs the national response. Delays in the receipt of accurate and complete reports, coupled with delays in data processing have contributed to inconsistent dissemination of information to stakeholders in the national HIV response.

WAY FORWARD

The system is informed by a public health questions approach to M&E of the HIV epidemic in Jamaica. Figure X outlines the main questions that must be addressed when planning a comprehensive national M&E system and lists the main data collection methods that can be used to answer these questions.

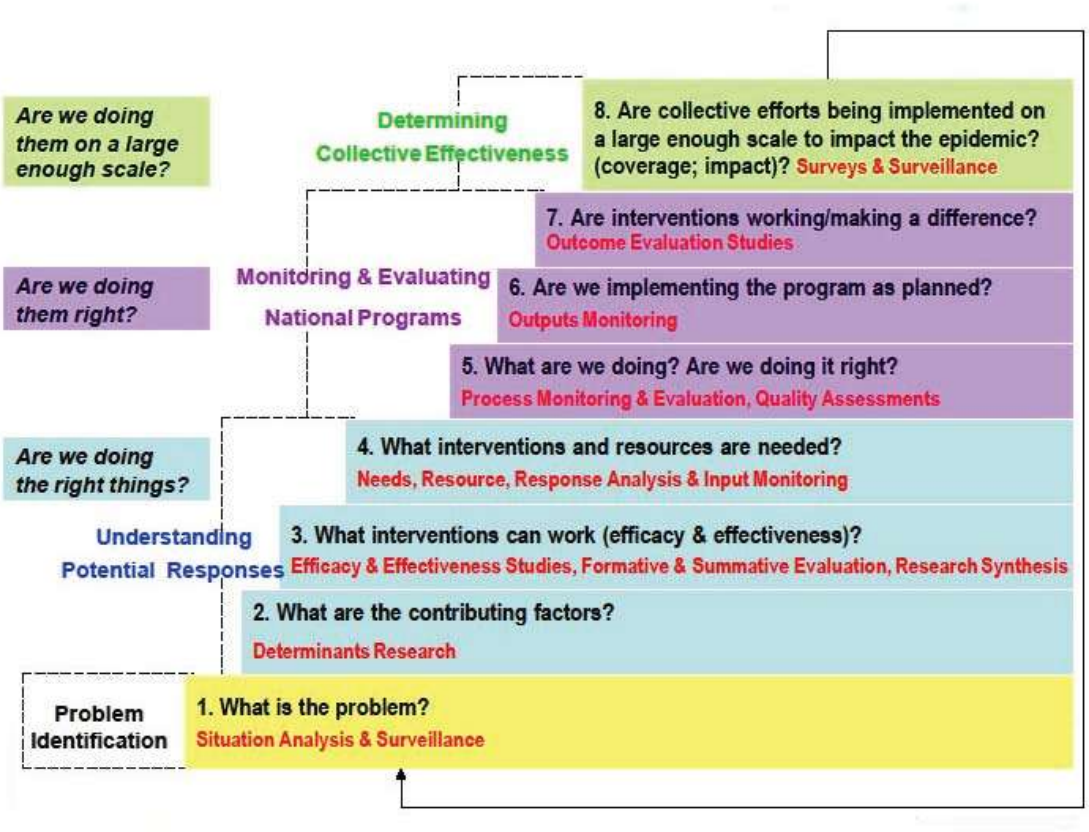


Figure X. A public health questions approach to HIV M&E (source: _)

Strategies implemented during 2013-2018 must ensure that data is made available that can increase our understanding of the epidemic, inform appropriate response, monitor the national programme, and determine the effectiveness of our national response.

Some of the critical areas that will be addressed in the HIV response under the M&E component include:

1) **Capacity building in M&E: Over** the last strategic planning period, ……M&E training workshops were conducted and……persons were trained including social workers, programme officers, laboratory personnel, BCC experts, medical doctors, nurses and contact investigators. Topics included basic M&E, data analysis and utilization and data quality. Limited training on outcome and impact evaluation was conducted despite the increasing need to answer evaluation questions. In addition, the high turnover of M&E staff among stakeholders demands that M&E training be on-going and institutionalized. M&E training will continue to be a priority and partnerships will be developed with CHART to ensure that basic M&E training on data collection tools are incorporated in planned training activities. In addition to this ongoing training, a more in depth module will be delivered by the M&E team that will support the development of M&E Plans, to include logframes and a

monitoring plan, for each stakeholder organization. Greater emphasis will be placed on training in evaluation and advanced M&E for strategically placed staff e.g. regional epidemiologists and M&E officers.

2) **Revision of the M&E plan and operations manual:** The M&E plan and operations manual will be reviewed to reflect any changes in the information system and be consistent with the strategies outlined in this strategic plan. The M&E system will be reviewed to assess gaps in the 12 components of a functional M&E system, and strengthening actions will be implemented to address these areas of weakness. Indicators will be reviewed to ensure that they are consistent with international definitions and targets will be revised based on the best available data at the time of the review. The updated operations manual will also include guidelines and standards for data management and quality assurance procedures within the National M&E Unit. Emphasis will be placed on supervision of data entry in databases as we move towards establishing a network of web-based databases. These areas will be reviewed periodically during the strategic planning period.

3) **Review and revision of data collection tools:** While great strides have been made in streamlining of data collection tools, the need for additional data dictates that data collection tools will have to be reviewed to ensure accurate collection of data. In addition, new tools will need to be developed where gaps in data collection exist. For example, data on HIV testing disaggregated by sex, monitoring data on syphilis, data on new pMTCT indicators. Data quality will be given greater attention including examining and strengthening sources of national health information such as the MCSR, which provides key indicators on the Elimination Initiative for syphilis and pediatric HIV.

4) **Strengthening monitoring of key populations:** The M&E unit conducts routine monitoring along with special studies among key populations at high risk for HIV infection. Interventions among these groups will be scaled up significantly in this strategic period, as recent epidemiological trends suggest a shift in the Jamaican epidemic from that of a generalized epidemic to one in which the epidemic is concentrated within most at risk populations. As the national response among key populations matures, the monitoring and evaluation activities will need to reflect and guide these efforts. The results from second and third generation surveillance in key risk groups must be reviewed with stakeholders to identify the gaps in programme monitoring and to revise selected indicators.

5) **Improving the electronic information system including the web-based databases:** Implementation of databases such as a web-based HATS, HIV treatment registers, and laboratory information systems have been sub-optimal. Inadequate support staff to maintain databases at parish and organizational level, interrupted power supply, inadequate human resources and limited buy-in by stakeholders have hampered implementation of databases. Under the new strategic plan, a project manager will be hired to ensure full implementation and maintenance of the web-based systems. The feasibility of linking HIV databases by a unique identifier will be re-examined. The M&E team will participate as far as possible in the development of the user requirements for the national Health Information System and ensure that the existing M&E information system is compliant.

6) **Data collection in the Private sector:** Significant progress has been made in collecting VCT data from Private Laboratories, however there has been little progress in engaging

private healthcare practitioners and private pharmacies in the M&E system. This gap in reporting limits our understanding of persons who are diagnosed or who seek treatment in the Private Sector. Representatives from among the private sector will be engaged through the MERG and their feedback will be sought in adapting existing data collection methods to suit their settings.

7) **Implementation of the research agenda:** Routine monitoring data is readily available from the existing information system but key questions on the HIV epidemic and the national response remain unanswered. Consultations with stakeholders informed the current research agenda, from which a number of studies are being implemented to varying extents. This research agenda will be reviewed periodically in the strategic planning period (at least biennially) and the lessons learned will be used to strengthen programme planning. The MERG will continue to be a forum for convening stakeholders involved in HIV research and discussion of the implication of findings. Such discussions and careful consideration of the findings of operational research will strengthen the HIV response.

8) **Data utilization and dissemination: A** previous assessment of Jamaica's M&E system identified dissemination of data captured by the M&E system as an important gap. In response, data dissemination was addressed in the M&E plan including web-site postings of epi updates, presentations at annual reviews and quarterly HIV meetings, journal articles and other publications. However, dissemination of data remains ad hoc at times and published data is often limited to surveillance data. In order to strengthen this component of the M&E system, a dissemination plan will be developed and implemented including an HIV bulletin, dissemination meetings for relevant operational research, review of data from electronic databases, and regular posting of reports on the NHP web-site.

9) Integration and sustainability: The value of the existing databases lies in the extent to which they are utilized for complete entry of primary data as well as the reliability and validity of their output reports. Refining the databases to ensure users find them valuable and efficient in the routine execution of their duties will be critical to sustainability. Secondly, to promote the integration of the existing system into the overall health system, the M&E team will participate as far as possible in the development of the user requirements for the national HIS and re-examine the feasibility of including HIV indicators in existing national data collection tools.