Country Progress Report

Jamaica

Submitted March 30, 2012

Acknowledgements

The submission of Jamaica's Global AIDS Response Report would not have been possible without the contributions and efforts of all stakeholders in the national response to HIV. Therefore, the National HIV/STI Programme wishes to extend sincere thanks to our funders and all stakeholders whose timely and accurate reporting of data made this Country Report possible.

Contents

List of Tables

List of Figures

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC(s)	Antenatal clinic(s)
ART	Antiretroviral therapy
ARV	Antiretroviral
BCC	Behaviour Change Communication
SW	Sex Workers
BSS	Behavioural surveillance surveys
ERTU-CHART	Epidemiology Research and Training Unit of the Caribbean HIV/AIDS Regional Training Network
FBO	Faith Based Organization
GIPA	Greater Involvement of People Living with HIV
HFLE	Health and Family Life Education
HIV	Human Immunodeficiency Virus
JaBCHA	Jamaica Business Council on HIV/AIDS
M&E	Monitoring and Evaluation
MNS	Ministry of National Security
MOEY	Ministry of Education & Youth
MOH	Ministry of Health
MSM	Men who have sex with men
MTCT	Mother-to-child transmission
NAC	National AIDS Committee
NCDA	National Council on Drug Abuse
NHDRRS	National HIV-Related Discrimination Reporting and Redress System
NHP	National HIV/STI Programme
NGO(s)	Non-governmental organization(s)
NPHL	National Public Health Laboratory
NSP	National Strategic Plan
OVC	Orphans and Other Vulnerable Children
PLACE	Priorities for Local AIDS Control Efforts
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
STI(s)	Sexually transmitted infection(s)
TCI(s)	Targeted community interventions
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary counselling and testing

Status at a glance

Country Profile

Jamaica is the largest English-speaking island in the Caribbean with a land area of 10,991 square kilometres and a total population of 2,705,800 (STATIN 2010 population figures). The island is divided into fourteen parishes. The capital city, Kingston on the South East coast and Montego Bay on the North Coast are the two main urban centres.

HIV affects persons in all 14 parishes, with the highest case rates in the most urbanized parishes (St. James and Kingston & St Andrew) and in tourist areas (North Western parishes). The HIV epidemic is closely tied to poverty, developmental and socio-cultural issues including the slow rate of economic growth, high levels of unemployment, early sexual debut, culture of multiple partnerships, and informal drug and commercial sex sectors.

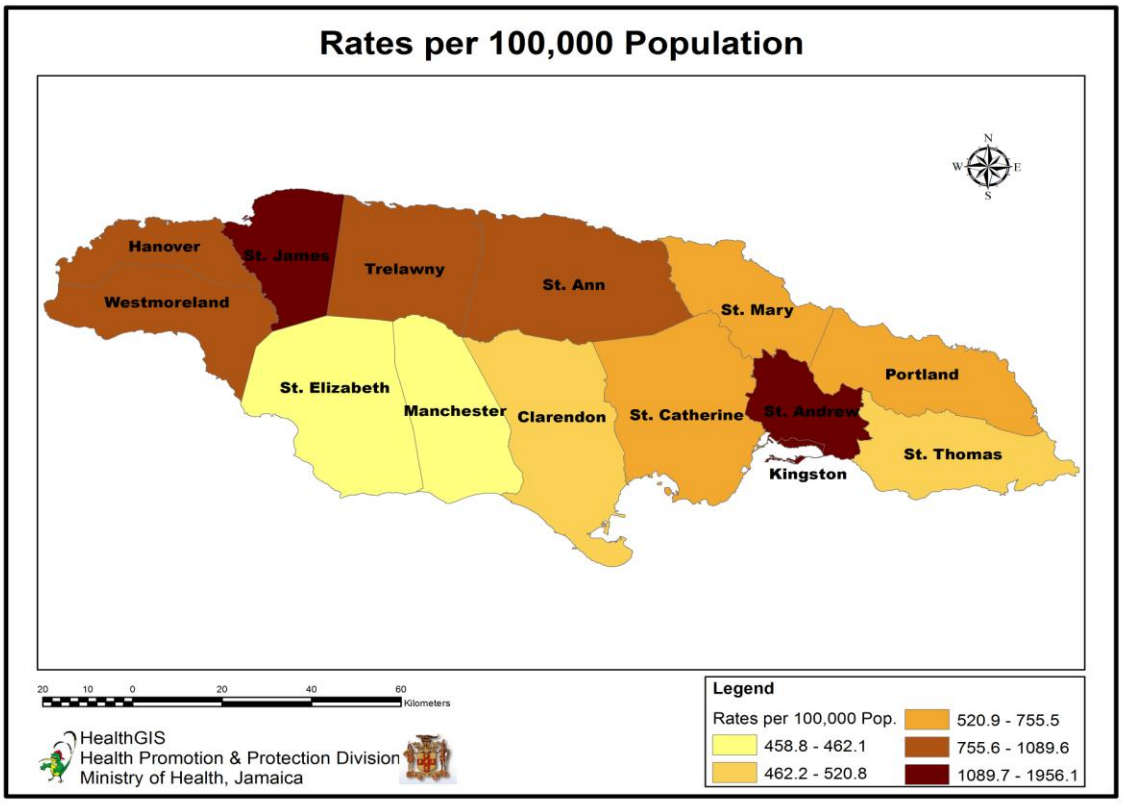


Figure 1: Cumulative reported AIDS case rates per 100,000, 1982 – 2010

According to epidemic modeling completed during the reporting period, approximately 1.7% of the adult population or 32,000 persons are living with HIV. Surveillance data show higher HIV prevalence in populations such as Men who have sex with men (32.8%), Sex Workers (4.1%), and homeless persons (12%) (Ministry of Health, 2010; Figueroa, 2012). The recently completed Modes of Transmission analysis estimates that 30% of new

infections in 2012 will be among MSM, 7% among female partners of MSM, and 7% among CSW and their male clients.

Jamaica's national response to the HIV epidemic is multi-sectoral and is guided by stakeholders from the Government of Jamaica, government ministries, non-governmental organizations, private sector groups, international development partners, and persons living with HIV. The national response is guided by a 5 year national strategic plan developed around 6 priority areas: Prevention; Treatment, Care and Support; Enabling Environment and Human Rights; Governance and Empowerment, Monitoring and Evaluation (M&E).

Inclusiveness of Stakeholders in the Report Writing Process

This document details trends in UNGASS indicators, the achievements and challenges of the Jamaica national HIV response, and future directions in order to achieve the vision of Jamaica's HIV response. This report draws heavily on the NSP 2012-2017 (Ministry of Health, 2012) and the accompanying M&E Plan, which were developed through extensive consultative processes. The M&E plan describes monitoring tools and special studies implemented by stakeholders to inform the indicators. The compiled report is reviewed and edited based on stakeholder consultations.

Notably, for the first time, the Jamaica country report will include the National AIDS Spending Assessment (NASA) and the Modes of Transmission (MOT) analysis. Stakeholder involvement was critical to the completion of each assessment. Over 54 persons representing civil society organizations, bilateral and multilateral agencies and UN organizations, private sector and government ministries participated in a National AIDS Spending Assessment (NASA) stakeholder workshop in October 2011. Twenty-eight organizations provided input into the NASA process. Preliminary findings were presented to over 150 stakeholders at the National HIV/STI Programme's annual review in November 2011.

The Modes of Transmission (MOT) analyses was initiated in October 2011 under the technical guidance of international and local consultants, with input from an expert group of local stakeholders from civil society, the University of the West Indies, and government. The expert group included stakeholders with expertise in epidemiology, prevention, behaviour change communication (BCC), and had extensive knowledge of high-risk populations. A technical working group, comprising key M&E staff, worked closely with the consultants.

The National Commitments and Policy Instrument (NCPI) was also completed in this reporting period. A management team was identified to oversee the implementation of the NCPI. This team included a consultant, a civil society representative and a monitoring and evaluation official. Interviewers from civil society and government were recruited to conduct interviews with key stakeholders in the national HIV response.

Table 1: Core Indicators for 2011 Political Declaration on HIV/AIDS, Jamaica Data January 2010 – December 2011

TARGETS	INDICATORS		PERFORMANCE
Target 1. Reduce sexual transmission of HIV by 50% by 2015 *General population*	1.1	Percentage of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission* [MDG Target: 90% by 2005; 95% by 2010] [National Target: 60% by 2011]	**Overall: 38.50%** **Men: 33.86% Women: 42.64% (2012, KABP survey)** 40.2% of 15-24 y.o. (2008, KABP) Men: 37.4% Women: 42.3% (2008, KABP) Women: 59.8% (urban); 57.9% (rural) – (2005, Multiple Indicator Cluster Survey)/ 38.1% of 15-24 y.o (2004, KABP) Men: 22.8% Women: 46.7% (2004, KABP)
	1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15 [National Target: TBD]	**Overall: 31.13%** **Men: 49.69%; Women: 13.51% (2012, KABP survey)** Men: 56.6% Women: 15.9% (2008, KABP survey) Men: 47.7% Women: 11% (2004, KABP survey)
	1.3	Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months [National Target: Men: 47% Women: 15% by 2008]	**Overall: 28.11%;** **Men: 46.77% Women: 13.28% (2012, KABP survey)** Men: 61.5% Women: 16.8% (2008, KABP survey) Men: 48% Women: 11% (2004, KABP survey)
	1.4	Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse* [National Target: None]	**Overall: 56.93%;** **Men: 65.38% Women: 40.19% (2012, KABP survey)** Men: 64.5% Women: 52.1% (2008, KABP survey) Men: 66.9% Women: 53.8% (2004, KABP)

TARGETS	INDICATORS		PERFORMANCE
	1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results [National Target: TBD]	**Overall: 58.71%;** **Men: 47.24% Women: 67.74% (2012, KABP survey)** Men: 20.2% Women: 35.4% (2008, KABP survey) Men: 12.2% Women: 18.3% (2004, KABP Survey)
	1.6	Percentage of young people aged 15-24 who are living with HIV* [Target: 25% reduction in most affected countries by 2005; 25% reduction globally by 2010] [National Target: ≤1.5% by 2009]	**0.78% (2011); 0.83 (2010, Spectrum Estimate)** **0.90% (2011, Sentinel surveillance of ANC clients)** **0.93% (2010) Sentinel surveillance of ANC clients)** 1.0% (2009, Sentinel surveillance of ANC clients) 1.3% (2007, Sentinel surveillance of ANC clients) 1.5% (2005, Sentinel surveillance of ANC clients) 1.1% (2004, Sentinel surveillance of ANC clients)
Sex workers	1.7	Percentage of sex workers reached with HIV prevention programmes	**79.7% SW (2011, Second generation surveillance)** This indicator was not determined in Second generation surveillance of SWs in 2008. Based on BCC Programme data, over 10,000 SWs were reached in 2008 and 2009 60% SW (2005, Second generation surveillance)
	1.8	Percentage of sex workers reporting the use of a condom with their most recent client [National Target: 95% by 2011]	85.2% of SW (2011, Second generation surveillance) Regular client: 91%; New Client: 97% (2008, KABP survey) 84.2% (2005, Second generation surveillance)

TARGETS	INDICATORS		PERFORMANCE
	1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results [National Target: 50% of SW by 2012]	**59.2% of SW (2011, Second generation surveillance)** 75% SW (2008, Second generation surveillance) 43% SW (2005, Second generation survey)
	1.10	Percentage of sex workers who are living with HIV [National Target: ≤7% by 2011]	**4.1% of SW (2011, Second generation surveillance)** 5% of SW (2008, Second generation surveillance) 9% of SW (2005, Second generation surveillance)
Men who have sex with men	1.11	Percentage of men who have sex with men reached with HIV prevention programmes	**86.9% (2011, Second generation surveillance)** **14% (2011, Based on programme records, 4617 men were reached in 2011 from an estimate population of 33,000)** This indicator was not determined in Second generation surveillance previously. Based on BCC Programme data, over 4,000 MSMs were reached in 2008 and 2009
	1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner [National Target: 60% by 2012]	**75.52% of MSMs (2011, Second generation surveillance)** 73% (2007, Second generation surveillance)
	1.13	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	**68.32% MSM (2011, Second generation surveillance)** 53% MSM (2007, Second generation surveillance)
	1.14	Percentage of men who have sex with men who are living with HIV [National Target: <25% by 2011]	**32.77% of MSMs (2011, Second generation surveillance)** 32% (2007, Second generation surveillance)

TARGETS	INDICATORS		PERFORMANCE
Target 2. Reduce transmission of HIV among people who inject drugs by 50 percent by 2015		Not Applicable	Not Applicable
Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths	3.1	Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission [National Target: 85% by 2009]	**58.68% - 284/484; (2011, Spectrum and PMTCT Programme Monitoring)** 84.3% (Dec 2011 – PMTCT Programme Monitoring) 86.3% (Dec 2010–PMTCT Programme Monitoring) 86.3% (Dec 2010 – PMTCT Programme Monitoring) 83% (Dec. 2009 – PMTCT Programme Monitoring) 85% (Jun. 2007 – PMTCT Programme Monitoring) 85% (2006 – PMTCT Programme Monitoring) 65% (2005 – PMTCT Programme Monitoring) 47% (2004 – PMTCT Programme Monitoring)
	3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	**87.1% (2011, PMTCT Programme Monitoring/ NPHL Lab Data)** **58.5% (283/484: 2011, Spectrum/ NPHL Lab Data)**
	3.3	Mother-to-child transmission (modeled)	**37 new infections (2011); 484 Women needing PMTCT (Spectrum Model)** **20 cases or 0.35 (per 1000) (2010 – PMTCT**

TARGETS	INDICATORS		PERFORMANCE
			programme monitoring) 14 cases or 0.25 (2009 – PMTCT programme monitoring) 18 cases or 0.32 (2008 – programme monitoring)
Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015	4.1	Percentage of eligible adults and children currently receiving antiretroviral therapy* [National Target: 8,008 Adults, 486 Children by 2012 or 75%. It is estimated that there are 14,000 Jamaicans living with advanced HIV in 2009 – Spectrum/EPP software]	**58.06% (9162/15779 January 2012)** 61% (Nov. 2007 – ARV Programme Monitoring) 53% (2006 – ARV Programme Monitoring) 50% (2005 – ARV Programme Monitoring)
	4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy [National Target: 85% by 2009]	**75.6% (2012, ARV Database)** 91% (2009, ARV database and chart review). 2009 data collected at 5/19 sites, which include sites representative of urban/ rural and large/ small populations 87.6% (2007, ARV database) 75% (2000, ARV Programme monitoring)
Target 5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015	5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	**10/45; 22.2% (WHO Estimate)** There were 32 HIV-positive incident TB cases in 2010. 10 were placed on treatment based on National eligibility criteria (2011 National TB Programme) 64% received co-trimoxazole; 72% received ART (2006 National TB Programme Records) There were 25 HIV-positive incident TB cases in 2006, and it appears that all who met criteria for ARV received such treatment.

<table>
<tr><th>TARGETS</th><th>INDICATORS</th><th></th><th>PERFORMANCE</th></tr>
<tr><td>Target 6. Reach a significant level of annual global expenditure (US$22 – 24 billion) in low- and middle-income countries</td><td>6.1</td><td>Domestic and international AIDS spending by categories and financing sources</td><td>Completed (2011, NASA)
<table><tr><th>HIV & AIDS Expenditure by Financial Source</th><th>JMD 2009/10</th><th>JMD 2010/11</th></tr><tr><td>Total Spending</td><td>1,321,746,436</td><td>1,276,015,167</td></tr><tr><td>Public:</td><td>299,096,806</td><td>334,859,307</td></tr><tr><td>Percent</td><td>22.6%</td><td>26.2%</td></tr><tr><td>International:</td><td>1,018,649,631</td><td>937,155,860</td></tr><tr><td>Percent</td><td>77.1%</td><td>73.4%</td></tr><tr><td>Private:</td><td>4,000,000</td><td>4,000,000</td></tr><tr><td>Percent</td><td>0.3%</td><td>0.3%</td></tr></table></td></tr>
<tr><td rowspan="3">Target 7. Critical Enablers and Synergies with Development Sectors</td><td>7.1</td><td>National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)</td><td>Completed (2012, NCPI, See Appendix 2)</td></tr>
<tr><td>7.2</td><td>Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months</td><td>9.89% (2012, KABP survey)</td></tr>
<tr><td>7.3</td><td>Current school attendance among orphans and non-orphans aged 10-14*

[National Target: >0.9% by 2012]</td><td>Unavailable (2010/11)
Male: 0.97 Female: 1.01
Urban: 0.99 Rural: 0.99
(2005 – Multiple Indicator Cluster Survey)</td></tr>
</table>

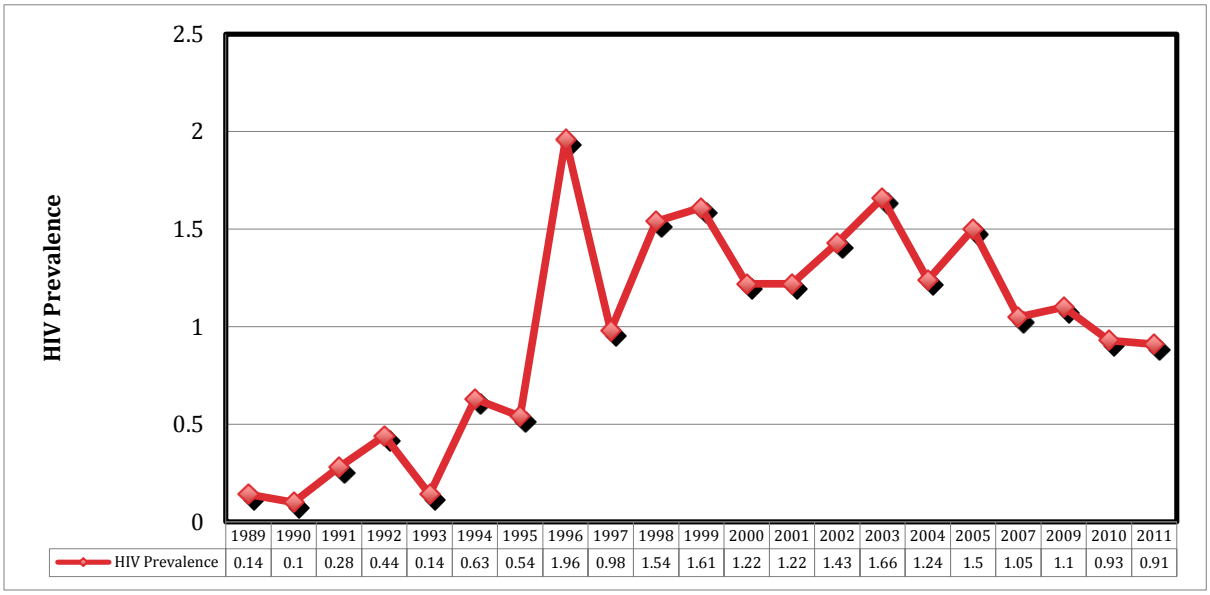
TARGETS	INDICATORS		PERFORMANCE
	7.4	Proportion of the poorest households who received external economic support in the last 3 months	Unavailable (2010/11)

Overview of the HIV Epidemic

Jamaica has an estimated 32,000 persons living with HIV or 1.7% of the adult opulation. Approximately one half of these persons are unaware that they are infected with HIV. While new HIV infections in Jamaica have declined by 25% in the past decade, it is estimated that as many as 2,500 Jamaicans will become newly HIV infected in 2012. HIV remains a leading cause of death among adults 15-49 years, with over 333 reported deaths due to AIDS in 2010.

Between 1982 and 2010, 27,272 persons were reported with HIV/AIDS in Jamaica and the cumulative number of reported AIDS deaths was 8,102. Young adults are the 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 rate among men continue to exceed AIDS case rate among women, though this gap has narrowed over the years (Duncan et al, 2010). In 2010, 46% of reported AIDS cases were among women.

Sentinel surveillance at antenatal clinic (ANC) sites was initiated in 1989 to estimate the impact of the epidemic in the general population. During the 1990s HIV prevalence increased rapidly among public ANC attendees, peaking at 1.96% in 1996 (Figure 2). Between 1997 and 2005 HIV prevalence among ANC attendees was relatively stable at around 1.5% with a decline to 1% starting in 2007. In 2010 and 2011, sentinel surveillance of ANC clients yielded HIV prevalence below 1% in both years.



	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2007	2009	2010	2011
HIV Prevalence	0.14	0.1	0.28	0.44	0.14	0.63	0.54	1.96	0.98	1.54	1.61	1.22	1.22	1.43	1.66	1.24	1.5	1.05	1.1	0.93	0.91

Figure 2: HIV prevalence among public antenatal clinic attendees (15 -24) in Jamaica, 1989-2011

Concentrated Epidemic

The emerging epidemiological data show a decline in HIV prevalence among ANC attendees, and STI clinic attendees. However the HIV prevalence among men who have sex with men (MSM), sex workers (SW), inmates and the homeless/drug users, remain high (Table 2).

HIV Prevalence	2008/2009	2010/11
Adults 15-49 years	1.6%	1.7%
ANC attendees	1.3% (2007) 1.1% (2009)	0.93% (2010) 0.90%(2011)
Female sex workers	9.0% (2005) 4.9% (2008)	4.1% (2011)
STI clinic attendees	2.4% (2009)	2.8% (2010)
Men who have sex with men	32% (2007)	32% (2011)
Inmates	3.3% (2003)	2.2% (2010) 2.5% (2011)
Homeless persons/Drug users	8.8% (2009)	12% (2010) 8.2% (2011)

Table 2: HIV Prevalence among key populations in Jamaica

Survey data suggest that HIV prevalence is declining among female sex workers (Figure 3). Jamaican female sex workers can be described as a highly mobile, heterogeneous group. They operate on streets, in exotic clubs, escort services, massage parlours and permeate the tourism industry. The decline in HIV prevalence among Jamaican sex workers (SW) is credited to decades of sustained interventions with this population. However, other most at risk populations such as MSM have not experienced such declines in HIV prevalence prompting review of strategies and the scale up of effective interventions.

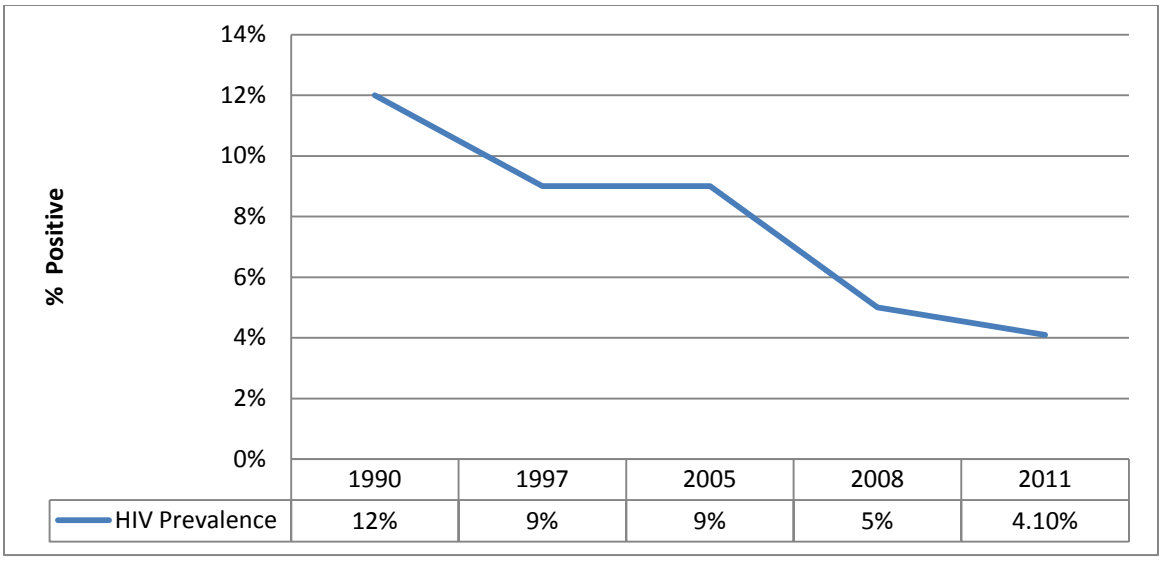


Figure 3: HIV Prevalence among SW, 1990 -2011

Modes of Transmission

Surveillance data indicates that over 90% of HIV infection among Jamaican men and women are attributed to heterosexual sex. 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 or reluctance on the part of the health care workers to probe sexual practices in interviews. This gap represents a significant weakness in the national HIV surveillance system.

In 2011, the UNAIDS Modes of Transmission (MOT) model was applied to the HIV epidemic in Jamaica. This model allows policy makers to gain an understanding of the short-term risk of HIV infection in various risk groups and guide the national HIV response. The MOT analysis utilizes data for key risk groups, including the proportion of adults in each group, the current HIV prevalence, patterns of risk and levels of protection against HIV infection in each risk group.

The model suggests that approximately 2,500 new HIV infections will occur in Jamaica in 2012. Approximately 30% of persons with new infections will occur in the MSM group, making MSM the group at highest risk of HIV infection (Figure 4). Female partners of MSM are also at significant risk with an estimated 7% of new infections coming from this group. Female sex workers, their clients and the partners of sex worker clients will also contribute significantly with approximately 10% of incident infections occurring in these groups. Twenty-three percent of new infections will be among persons engaging in casual heterosexual sex. This includes unattached youth, STI clinic attendees, homeless drug users, and heterosexual men and women with high risk behaviours. The distribution of incident cases supports the characterization of a concentrated HIV epidemic. However, the modeling process reinforces that, in Jamaica's context, HIV risk is not isolated to high risk groups as bridging populations may lead to the epidemic becoming generalized again over time.

Injection drug use, blood transfusion and occupational exposure risk groups were not included in the model as these modes of transmission do not contribute significantly to the Jamaica HIV epidemic based on surveillance data.

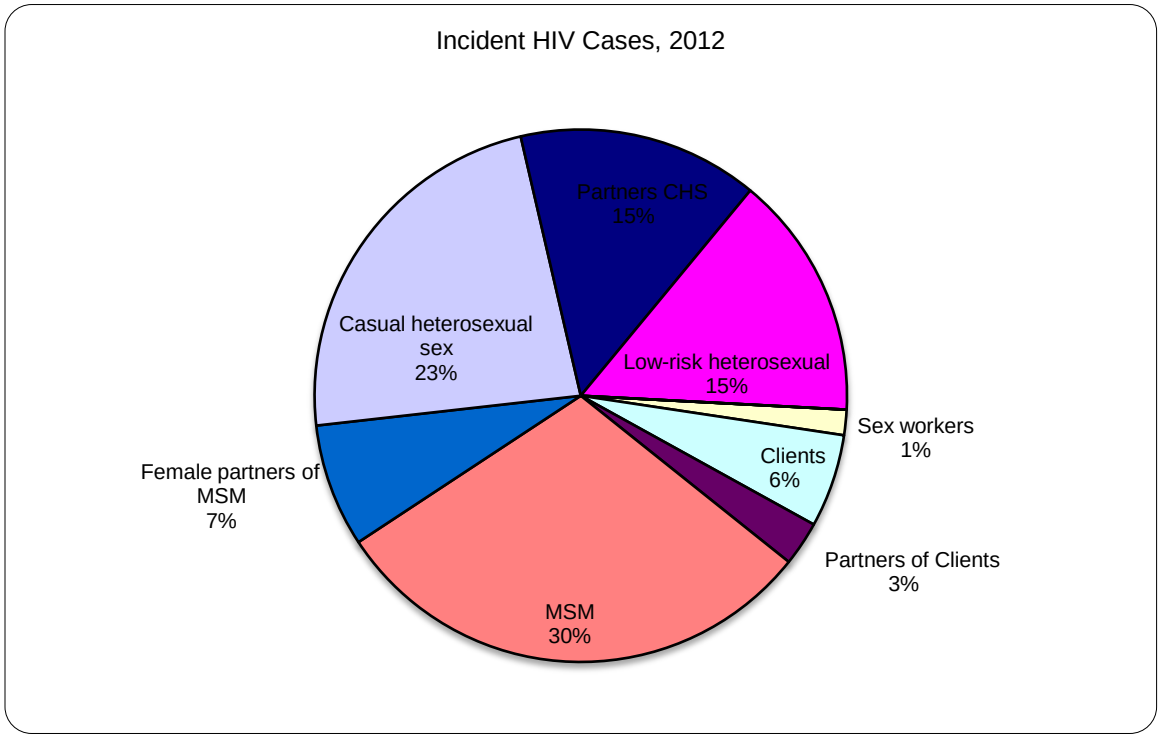


Figure 4: Distribution of incident HIV cases in Jamaica, 2012

Policy and Programmatic response

In response to the HIV epidemic, 6 priority areas were identified by the national response: Prevention, Treatment, Care and Support, Enabling Environment and Human Rights, Governance and Empowerment, Monitoring and Evaluation (M&E) and sustainability. In 2010 - 2011 the HIV epidemic profile of Jamaica showed a shift from a generalized epidemic to one in which HIV infections are largely concentrated in key populations such as MSM. MSM are estimated to represent 4.4% of the adult male population and account for an estimated 30% of new HIV infections. In response to emerging epidemiological data, prevention strategies to reduce HIV transmission in high risk groups were scaled up significantly and treatment programmes were expanded.

By the end of 2011, 8675 adults and 487 children with advanced HIV were started on antiretroviral (ARV) treatment. The number of persons with AIDS and AIDS deaths decreased by 17% and 40% respectively between 2004 and 2010 and the 12-month survival of persons initiating treatment in 2009 and 2010 was 86% and 73% respectively. The number of HIV tests done annually has more than doubled from less than 100,000 tests per year prior to 2004 to over 250,000 in 2010 and 258,000 in 2011. Nearly all pregnant women attending public clinics in 2010 and 2011 were tested for HIV. In a national survey, 95% of women who were pregnant in 2010 and 2011 and received care in public and

private facilities reported receiving VCT during antenatal care (KABP, 2012). Most (84%) HIV infected pregnant women and 98% of HIV exposed infants received ARVs in order to prevent mother to child transmission in 2011.

National Response to the HIV Epidemic

Policy and Legislative Framework for Prevention and Treatment

The Jamaican government continued to demonstrate their commitment to the HIV response during this reporting period in various ways including the involvement of high level leadership and support for HIV policy initiatives. Such commitment was evident on April 29, 2011 when the then Prime Minister, Honourable Bruce Golding and the then Leader of the Opposition, the Most Honourable Portia Simpson Miller signed a Declaration of Commitment to eliminate stigma and discrimination and gender inequality affecting the HIV response in Jamaica. This Declaration will provide leverage for the passage of policy and legislation to address HIV related stigma and discrimination and gender inequality for all who are infected and affected by HIV in Jamaica.

Figure 5: Signing of the Declaration of Commitment to eliminate stigma and discrimination and gender inequality on April 29, 2011, Kingston, Jamaica.

In the photo from left to right:
Seated: Hon Portia Simpson Miller, Leader of the Opposition, The Most Hon Orette Bruce Golding, Prime Minister of Jamaica
Looking on are: Dr Kevin Harvey-Director, National HIV/STI Programme; Dr Pierre Somse- UNAIDS Country Coordinator Jamaica, Belize and Bahamas at UNAIDS; Ambassador Pamela Bridgewater-United States Ambassador to Jamaica; Dr Ernest Massiah- Director of the UNAIDS Regional Support Team for the Caribbean; Hon Rudyard Spencer- Minister of Health; Earl Witter, QC, Public Defender

Monitoring stigma and discrimination has been identified as a programmatic priority under the enabling environment and human rights component of the NSP. The National HIV-Related Discrimination Reporting and Redress System (NHDRRS) continued to be

guided by the multi-sectoral Advisory Group, which was established in 2009. The group consists of representatives from the NHP, JNPlus, the Ministry of Health, Ministry of Labour and Social Security, National AIDS Committee (NAC) and the Legal and Ethical Subcommittee of the NAC, Jamaica AIDS Support for Life (JASL), Jamaica Independent Council of Human Rights and UNAIDS. In February 2011, the investigative capacity of the system was expanded by training 15 persons to be investigators that validate the complaints made to the system. During the period, 5 advisory group meetings were convened. The NHDRRS was further strengthened by the engagement of the Public Defender, the Nursing Council of Jamaica and the Ministry of Education in the redress and resolution of cases of alleged discrimination within the public sector. One hundred and ninety-five cases were documented since 2005, including 13 cases in 2010 and 19 cases in 2011. Redress was initiated on all cases reported to the NHDRRS between November 2010 and October 2011.

Other important policy and legislative initiatives during the reporting period are summarized below.

- In 2010, both Houses of Parliament, the Senate and the House of Representatives accepted the report and recommendations of the Special Select Committee appointed to examine the National Workplace Policy on HIV/AIDS. This policy provides a rich platform for implementation of the national workplace policy programme. Between 2007 and 2012, 70 large private sector companies have participated in workplace sensitization and training interventions, with 37 companies adopting workplace policies on HIV. In 2011, over 220 large private sector companies were reached through the HIV Workplace Programme; of that number more than 160 had developed workplace policies and/or action plans. The adoption of workplace HIV policies will protect employees from stigma & discrimination and provide care and support for those infected and affected by HIV in workplaces. All government ministries and agencies have developed HIV/AIDS workplace policies. Notably in December 2011 the Ministry of Health, Youth Sports and Culture and the Office of the Services Commission launched their HIV Workplace Policies.

- The private sector has shown commitment to adopt workplace policies on HIV and to participate in Jamaica's HIV response. The Jamaica Business Council on HIV/AIDS (JaBCHA) has taken the lead in mobilizing private sector resources and, with the assistance of the NHP and USAID, the JaBCHA National Foundation was started in April 2011 and launched in July 2011. This Foundation was established to mobilize and expend funds for HIV/STI related initiatives and to sustain Jamaica's national HIV response.

- Recommendations continue to be made to Jamaica's legislative and policy framework to create a more enabling environment for people who are infected or affected by HIV. These include a cabinet submission on the amendment to the Public Health (Class 1 Notifiable Diseases) Order which was prepared for submission to Parliament in May 2011. The proposed amendment seeks to remove provisions that are prejudicial to PLHIV as it relates to access to education, certain public facilities and employment within the food and tourism industries. Throughout the latter part of 2011 the cabinet submission received comments and endorsement from the Ministries of Labour and Social Security, Tourism, Education, Justice and the Attorney-General's Department. During this same period a report recommending the repeal of the Venereal Diseases Act was also sent to the Ministry of Justice for action.

- Jamaica, through the Ministry of Labour and Social Security in collaboration with the Jamaica Employers Federation (JEF), and the Jamaica Confederation of Trade Unions (JCTU), is one of 16 countries to implement the International Labour Organization (ILO) HIV Workplace Education Programme. The Voluntary Compliance Programme (VCP) is one of the initiatives designed and implemented by the Ministry of Labour and Social Security to encourage involvement of companies in the ILO's HIV Workplace Education Programme. Through the VCP, companies are provided with technical assistance and guidance in the adoption of HIV workplace policies. Such adoption is in preparation for the passage of the Occupational, Safety and Health (OSH) Act and HIV Regulations, which were drafted in 2010 and are based on the 10 ILO principles on HIV and AIDS and the world of work. These regulations will give legislative effect to the National HIV/AIDS Workplace Policy and among other things will require private and public sector entities to adopt and implement polices within the workplace to address issues related to HIV. These regulations will be appended to the Occupational Health and Safety Act, which is on the 2011/2012 Legislative Agenda for Parliament.

- On December 1, 2011 the Ministry of Labour and Social Security has launched its Food Industry intervention in order to directly address discrimination and discriminatory practices within the industry towards HIV and persons with HIV/AIDS.

- In 2011, a situation analysis for development of policy on access to voluntary confidential counselling and testing (VCCT) for minors was conducted. The particular focus is on access by minors below the age of 16 to VCCT without parental consent. As a result, a concept paper that will guide the development of the policy is being developed.

- The involvement of Faith Based Organizations (FBOs) in the HIV response was examined in 2011 as qualitative research was conducted to determine attitudes and perceptions of faith based leaders towards HIV and most at risk populations. The studies covered knowledge, attitude, practices and behaviours as well as stigma and discrimination in relation to HIV and key populations. In depth interviews were conducted with 20 high level faith-based leaders and 5 focus group discussions hosted 40 leaders. The findings continue to be disseminated through various fora and are used to inform stigma and discrimination reduction interventions as well as the development of training and BCC tools. This includes a docudrama for faith based leaders and community members. During 2011, HIV sensitization sessions were also held with over 500 faith-based leaders and community members.

- In October of 2011, Jamaica presented its third periodic report to the Office of the United Nations High Commissioner for Human Rights, Human Right Committee, 103rd Session in Geneva.

- The Minister of Health through the National AIDS Committee led a high level delegation to the 2011 United Nations General Assembly High Level Meeting on AIDS. Accompanying the Minister were representatives from the Ministry of Foreign Affairs and Foreign Trade and the National HIV/STI Programme. The official delegation was completed by representation from civil society (JASL and EVE for Life) and the private sector (Jamaica Business Council on HIV/AIDS).

Greater Involvement of Persons with HIV/AIDS (GIPA)

The Greater Involvement of Persons with HIV/AIDS (GIPA) continues to be facilitated through the GIPA coordinator and GIPA facilitator under the purview of the Enabling Environment and Human Rights Component. The sub-project operates on four main levels:

1. To expand the participation of PLHIV in existing interventions on request such as workshops in the workplace programme by delivering sessions on Basic HIV/AIDS Facts, GIPA and the National HIV Related Discrimination Reporting and Redress System (NHDRRS);
2. To participate on special committees and panels representing the PLHIV community on request;
3. To coordinate the selection, sensitization and training of 20 PLHIV per year for their greater involvement in risk reduction and HIV-related discrimination reduction interventions;
4. To assist the Jamaican Network of Seropositives (JN+) and NHDRRS through active participation in selected interventions.

A series of activities were facilitated during 2010 and 2011. The following gives main highlights of the sub-project.

- Twenty-two PLHIV were trained in HIV Basic Facts, positive prevention, HIV/AIDS and the World of Work, GIPA and disclosure issues, human rights, stigma and discrimination. Throughout the period, GIPA related sessions were conducted by PLHIV within existing meetings and training programmes in the workplace.

- A needs assessment was conducted to determine the basic needs of PLHIV (knowledge, skills and psychosocial needs) in order to enhance participation at workplaces and contribute to the national HIV response. The findings, conclusions and recommendations informed a training programme and resulted in the training of a cadre of PLHIV to be part of the HIV workplace interventions in the public and private sectors. In addition, there was provision of greater support to the Self-Support Groups/Support Groups.

- Other capacity building interventions were conducted for PLHIV. The objective of these sessions was to improve the knowledge and skills of select PLHIV regarding JN+, basic facts on HIV & AIDS, workplace principles, anti-stigma and discrimination issues, NHDRRS, and positive health, dignity, and prevention. Such capacity building equipped PLHIV to function as presenters and workshop trainers. Fifty-five sessions were conducted in various sectors in collaboration with Workplace Programme Officers. The entities include government ministries (including departments and agencies), private sector companies, civil society organizations such as FBOs and PLHIV network and groups.

- Progress was made by GIPA towards monitoring and evaluating PLHIV trainees as they conducted sessions in pre-selected workshops and self-support groups.

Gender Mainstreaming in the National HIV Response

Harmful gender norms such as masculine dominance and feminine submission, cross generational sex, multiple partners, gender based violence and homophobia are important factors in Jamaica's HIV epidemic. Recognizing the importance of gender, the Government of Jamaica through the Ministry of Health in partnership with UNWOMEN, formerly UNIFEM, and the European Commission strengthened gender equality mainstreaming efforts, which were initiated in the 2007 - 2012 National Strategic Plan. This was implemented by the National HIV/STI Programme (NHP) and the National AIDS Committee (NAC) as well as the NGO, Jamaica AIDS Support for Life (JASL).

Studies were conducted by the NHP and JASL to identify gaps in gender mainstreaming in the national response and in services to HIV positive women, including human rights issues. Areas for strengthening were identified through desk review of HIV policies and programmes as well as consultations with various stakeholders. This informed the capacity building focus of the NHP's gender mainstreaming process. Over twenty three (23) months from May 2010, 200 women and men were trained to address gender dynamics and to recognize links between gender equality and human rights in seeking to halt and reverse the HIV epidemic. Training in gender analysis skills was also incorporated to better assess and transform interventions with the most at risk populations to ensure that interventions were gender responsive and reduced gender related stigma and discrimination. This was also achieved through partnership with the Institute of Gender and Development Studies at the University of the West Indies where a course entitled "Gender, Sexual and Reproductive Health and HIV/AIDS" was conceived. A training resource on Gender and HIV was also piloted within the training programmes.

Prevention, Knowledge and Behaviour Change

Prevention Strategies

During the reporting period, the National HIV/STI response continued to scale up key strategies to establish a comprehensive programme of prevention services that address social vulnerability and risk behaviors among sexually active men and women. This includes an increased focus on MARPs such as MSM, SW, and crack/cocaine users.

Media Campaigns: Several major media campaigns were launched or relaunched in 2010 and 2011. These campaigns were designed to position critical HIV issues on the public agenda. Such issues include gender specific HIV risk behavior and cultural norms that underlie these practices, promotion of condom use, and sensitization of the public to the role of the Health and Family Life Education (HFLE) curriculum. The following campaigns aired in 2010: **Stick to ONE Partner** (targeting multiple partners among men); **Smart Women Always Buy, Carry and Use Condoms** (targeting women and condom use); **Health and Family Life Education Curriculum**; **Prevention of Mother to Child Transmission (PMTCT)**; **Adolescent Docudrama**; **Pinch, Leave an Inch and Roll** (providing condom use tips); **Get Tested: Ah Nuh Nutten** (aimed at voluntary counseling and testing or VCT for men). In 2011 **Smart Women Always Buy Carry and Use Condoms** was launched again; **Real Man Nuh Ride Widout Condom** (targeting condom use by men); **Paradise for Real** - Ministry of Tourism (targeting transactional/commercial sex and condom use in the tourism sector.

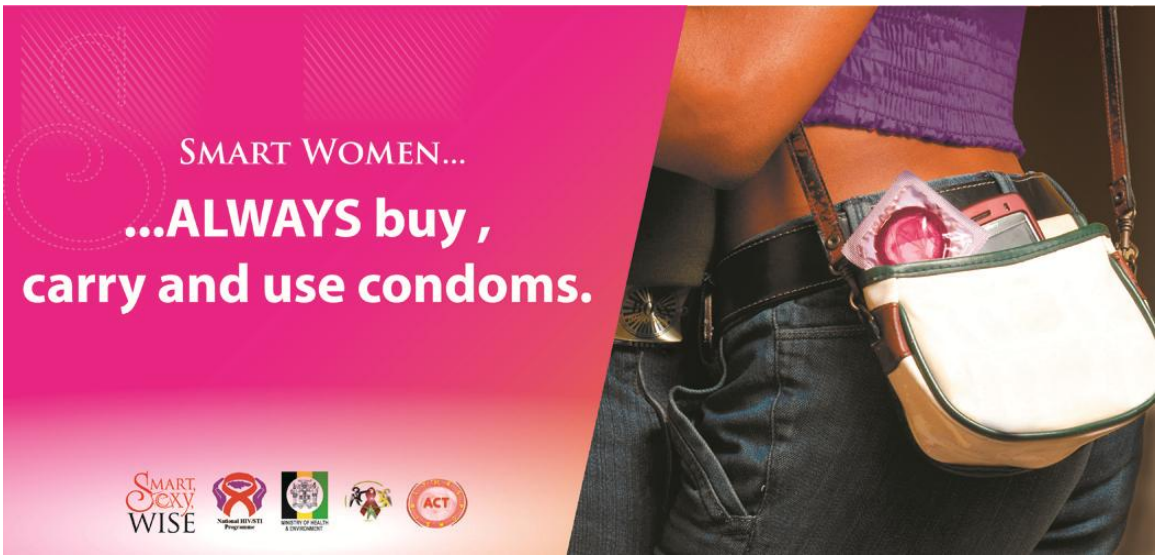


Figure 6. Media campaign launched in 2010 to promote condom use among women

Targeted interventions among MARPS

The development of targeted interventions was informed by the HIV Prevention

Working Group, which was established in April 2010. The group provides a forum to review, evaluate and assess prevention efforts for Jamaica's MARPs in order to identify gaps, build consensus regarding the prevention response and document best practices. It includes stakeholders from the public and private sectors as well as civil society.

Men who have sex with men (MSM), Sex workers (SW), and Out-of-school-youth (OSY). In 2010 and 2011 the Regional Health Authorities and NGOs, which include Jamaica Red Cross, Jamaica AIDS Support for Life (JASL), Children's First, the Joy Town Community Development Foundation and Hope Worldwide, combined efforts to provide empowerment workshops for their different target groups (MSM, SW, and out of school youth). The aim of the empowerment approach is to reduce the social vulnerability and individual risk level of participants. Participants benefitted not only from HIV/AIDS information, VCT and prevention tools but also from exposure to information and services offered by social agencies. Participants were exposed to programmes offered by HEART Trust NTA, Registrar General's Department (RGD), Jamaican Foundation for Lifelong Learning (JFLL), the National Council on Drug Abuse (NCDA) and financial institutions. These agencies and institutions assist in addressing issues of employability, literacy and drug use.

Figure 7: A group of Jamaican female SW listening keenly to a presentation at an empowerment workshop

Homeless Drug Users. The National Council on Drug Abuse (NCDA) received support to target homeless persons and drug users with a coordinated prevention and treatment approach. The emphasis was placed on linking HIV positive substance users to HIV treatment, prevention and care services, rehabilitation and detox services, and where possible, reuniting persons with their families. Key partnerships with private sector, small businesses and charitable organizations facilitated the provision of food, shelter, medical care and medication to such persons.

Inmates. Throughout 2010, the Department of Correctional Services (DCS) tested 1048 inmates in major receiving institutions and sensitized approximately 1385 inmates on HIV/AIDS basic facts. The department continued to implement the Inmate/Prison Intervention Strategy and expanded the program to have routine HIV testing at all

correctional facilities in 2011.

Adolescents in School. The "Hold On, Hold Off" school intervention complimented the Ministry of Education's revised HFLE Curriculum and strategy by focusing on students and schools situated in lower income communities with HIV, sexual and reproductive health, and life skills based information, amongst other critical areas.

The Targeted Community Intervention (TCI). The targeted community intervention (TCI) strategy is designed to reach key populations in communities with high HIV prevalence. Within this context, the most-at-risk include males and females 19 -39 years, out-of-school youth, as well as female SW and MSM. The TCI is implemented in four phases including observation and determination of baseline risk behaviours and working alongside community members to conduct several specific activities that result in community involvement, ownership and empowerment to reduce HIV transmission.

HIV Outreach Team (H.O.T). The HIV Outreach Team was conceptualized as one of the strategies to meet the growing demand for scaling up HIV testing services in the South East Region. The team is attached to the NHP's wider Prevention Unit and comprises 12 outreach officers and 2 field coordinators. HOT officers' duties include: prevention interventions at PLACE sites, targeted community interventions, site based interventions targeting key populations and more recently, outreach testing using mobile testing units. In 2011, the HOT team provided HIV testing to 10,191 women, and 7,077 men. The unit also supports syphilis testing, and in 2011, 5463 men and 7699 women were tested for syphilis.

Knowledge and Behaviour Change

The main source of data on the impact of prevention efforts on knowledge and behavior change in Jamaica's population is the Knowledge, Attitudes, Behaviour and Practices (KABP) survey. Conducted every 3-4 years since 1990, the KABP survey has shown that 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 sexual risk behaviours tend to be more culturally acceptable for men than for women, and so they remain significantly higher among men than women, although women tend to under report risk behavior more than men due to social acceptability bias (Hope Enterprises, 2008).

The most recent KABP, conducted in 2012, was a cross sectional, household based, survey of a randomly selected sample of 1800 persons island-wide. Respondents represented persons aged 15 – 49 years, with the younger group of 15 – 24 year old being over sampled to facilitate more robust analysis.

The KAPB 2012 preliminary data suggest important shifts in the key drivers of the epidemic when compared to 2008 findings. First, fewer respondents reported multiple partnerships, fewer young people reported having sex before age 15, and the proportion of the adult population that have tested for HIV and know their status in the past 12 months have more than doubled. These changes reflect the expansion of the HIV testing programme, national campaigns on partner reduction and abstinence (media campaigns, HFLE and youth focus interventions). Despite these successes, a number of the key drivers

of the epidemic persist. HIV knowledge indicators have not improved over the last decade; in fact HIV knowledge decreased among men in 2012 when compared to 2008 (33.8% vs. 37.4%, respectively). Fewer men had comprehensive HIV knowledge in 2012 but the indicator was unchanged among women (42% in 2012 and 2008). Previous surveys confirm that knowledge about HIV prevention is high (consistent condom use, abstinence and one faithful uninfected partner) but this indicator value is largely driven by failure to appropriately reject myths such as HIV transmission by mosquito bites.

Reported condom use among persons with multiple partners was suboptimal and showed no change among men and a worrying decrease among women with fewer women with multiple partners reporting condom use at last sex (65.4 vs 64.5% of men; and, 40.2% vs 52.1% of women, in 2012 and 2008, respectively). Condom use was lowest among adult women (33%) compared to young women (43%) and adolescents girls (48%). Declines in social and economic conditions may be eroding the ability of women, who often head single-parent families, to negotiate condom use. Sexual and physical violence was reported by 9.9% partnered or ever-married women and further increases vulnerability. Also, transactional sex, defined as the exchange of gifts or money for sex, within the last 12 months was a common feature in the survey sample (49% of men and 20.7% of women). No recent data on adolescents is available and there is concern about similar high risk behaviours.

Considering the MOT estimates for HIV incidence in this group of high risk persons, the need to develop effective strategies to combat this downward trend is paramount, as this could ultimately undo gains made in reducing HIV in the general population. Prevention partners in the national response must increase their commitment to developing and delivering evidence-based interventions that target these specific behaviours.

Most at risk Populations (MARPs)

In 2010 and 2011 the MSM and SW interventions evolved into a more holistic approach that incorporate economic and social vulnerability as well as culture and lifestyle of the groups. Cultural factors are thought to increase vulnerability of at risk populations by down-playing, and even endorsing, risky behavior. The prevention component of the NHP systematically strengthened and expanded interventions to reach the most at risk populations throughout the island. The second generation behavioural surveillance of both MSM and SW were completed in 2011.

These surveys revealed a further decline in the prevalence among SW (9% in 2005 to 4.1% in 2011). HIV prevalence remained unchanged among MSM, holding to the 2007 level of 32%. Testing among MSM increased and surpassed the percent of SW reporting HIV testing in the last 12 months (68.9% vs 59%). The reported HIV testing in the past 12 months doubled among MSM (33% (2007) and 68.9% (2011). In comparison to the survey data from 2007 (MSM survey) and 2008 (SW survey), reported condom use increased marginally among MSM from 73% to 77%. However, these levels of condom use may reflect the social desirability of a positive response in this sample of 453 MSM. Condom use declined marginally among SW from 91% to 85%. The majority of MSM and SW report being reached by prevention efforts in the past 12 months (87.4% MSM and 79.7% SW) but many did not answer questions about HIV prevention and transmission appropriately (55% MSM and 38% SW). However, comprehensive knowledge about HIV was generally higher

than recorded for men and women in the general population.

The NHP has a longstanding history of interactions with the SW community and prevention interventions such as HIV /STI testing and condom promotion are often welcomed. However, increase in discreet sub-populations in recent years, such as SW in massage parlours and clubs, have proved to be challenging due to gate keepers and new structural barriers that hinder prevention activities (e.g. HIV testing).

Access to the MSM population is also challenging as stigmatization drives MSM underground and some MSM fail to identify the risk associated with their sexual practices. Behavioral and structural barriers result in slower changes in adoption of protective, low risk behaviour. The legislative and policy environment serve as a key barrier to providing access to prevention and treatment services that will likely reduce the impact of HIV on this population.

Treatment

The impact of the treatment program is reflected in surveillance data that documents a decrease in the number of reported AIDS deaths from 665 persons in 2004 to 333 persons in 2010. Preliminary data indicates that the <5% chance of HIV transmission from mother-to-child was sustained in 2010 and by case definition, the elimination of congenital syphilis was achieved in 2010. Expansion of the HIV programme has also resulted in increased access to HIV testing, which has contributed to earlier diagnosis of PLHIV and timelier access to ARV treatment. During the reporting period over 500,000 HIV tests were conducted by the Regional Health Authorities, private sector and other facilities.

Access to ART and Medical Management

In 2011, 23 treatment sites continued to provide multidisciplinary care to PLHIV in Jamaica. All sites are located in facilities that provide other health services, making care for PLHIV available in an integrated service setting. This comprehensive treatment (including ARVs) is free of cost in the public sector. Of the estimated 32,000 PLHIV in Jamaica in 2010, approximately 14,000 were in need of ARV treatment. Since public access to antiretroviral treatment (ART) was introduced in 2004, approximately 1,000 to 1,500 PLHIV were placed on treatment each year. By the end of 2011, 9,162 persons with advanced HIV were started on ARV treatment. However, persons who are lost to follow-up and inconsistent use of HIV electronic databases have resulted in a decline in indicators aimed at determining survival on ART (indicator 4.2).

During the period, the NHP continued to dispense ARVs from treatment site pharmacies and Drug Serv pharmacies. The treatment programme was strengthened by the addition of 3 private pharmacies as points of access for ARVs to public and private sector clients. NHP/MOH certified practitioners continued to offer service to PLHIV who preferred to access care in the private sector. These private sector patients were also able to access ARVs free of cost through the Drug Serv and 3 private pharmacies involved in the programme. The NHP's treatment programme recognizes that the benefits of ARV extend beyond delaying disease progression and AIDS death, but also reduce HIV transmission to HIV negative partners. Achieving universal access to ARV will reduce the number of new HIV infections and contribute to the declining trend in HIV incidence.

Laboratory Capacity to Identify Indicators of Progression of Infection /Immune Impairment (CD4 Count, Viral Load, PCR)

During 2010, access to CD4 testing was increased by the introduction of PIMA machines at 3 treatment sites: Port Antonio and Black River Hospitals and Jamaica AIDS Support for Life, Kingston Branch. This testing methodology eliminates the need to ship all samples to the National Public Health Laboratory (NPHL) in Kingston or the Cornwall Regional Hospital, and is expected to improve access to CD4 testing due to the fragility of the required sample for CD4 testing.

Viral Load testing in the public sector was conducted solely at the NPHL, which is the only public laboratory in Jamaica with this capability. The national HIV treatment guideline recommends that viral load determination should be carried out primarily to evaluate the

benefit of HAART. It is recommended six months after the initiation of HAART then annually thereafter.

Dried Blood Spot (DBS) samples for DNA PCR testing of HIV exposed infants, which was introduced in 2009, was fully implemented at all treatment sites by the end of 2010. The number of samples that are submitted for early infant diagnosis by polymerase chain reaction (PCR) has increased each year since its introduction.

Elimination of Mother-to-Child Transmission of HIV and Syphilis

With regards to congenital syphilis, based on the transmission rates for the period 2008 to 2010, Jamaica has achieved the elimination target (3 consecutive years of transmission rates < 0.3 per 1000 live births). The transmission rates ranged from 0.15 to 0.21 cases per 1000 live births for the three year period.

Relating to HIV, the PMTCT programme has resulted in provision of ARVs to 87% of pregnant women and 98% of infants delivered in the public sector in 2011. The programme has maintained this level of performance since at least 2006. While data from the private sector are unavailable, national surveys and surveillance data such as paediatric AIDS and paediatric AIDS deaths suggest that similar coverage exists in the private sector.

	2005	2006	2007	2008	2009	2010
# ANC Attendees Tested	28,651 (96%)	28,446 (95%)	22,478 (95%)	29,119 (>95%)	30,076	26,697
# HIV +ve women delivered	401	442	358	616	440	432
% of women getting ARVs	**74%**	**84%**	**84%**	**84%**	**84%**	**86%**
# of HIV – exposed infants	407	433	362	612	439	419
# Infants getting PMTCT	**353 (87%)**	**403 (93%)**	**350 (97%)**	**605 (98%)**	**430 (98%)**	**408 (97%)**
Transmission Rate	**10%**	**<10%**	**<5%**	**<5%**	**4.3%**	**4.6%**

Table 3. Jamaica's prevention of mother to child transmission programme data, 2005 to 2010

Challenges in Treatment

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

- **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 some categories of human resources (adherence counsellors) are solely grant funded. As funding declines, the financial support for these critical inputs have not been clearly identified.

- **Staff shortages -** There is also a severe shortage of human resources in the field and this may be one of the greatest limitations to programme success. The lack of adequate numbers of Medical Officers of Health to manage HIV programmes as well as the general shortage of doctors, nurses, pharmacists, social workers and counsellors limits the implementation of the treatment programme. The lack of pharmacists is a critical gap that results in extended waiting times at pharmacies.
- **HIV Testing -** It is estimated that potentially 15,000 persons who are HIV infected do not know their status. To achieve the ARV coverage target, HIV testing of key populations with high HIV prevalence must be expanded since current data suggests that HIV testing interventions fail to include many persons with very high risk behaviours.
- **Adherence -** Individual adherence to medication is a major challenge and negatively impacts the success of the treatment and prevention programmes. Poor sequencing of ARVs by some physicians also needs to be addressed.
- **ARV supplies management -** In spite of free access to ARVs, there are challenges along the supply continuum which affect patient care. Poor internal management systems at the central warehouse negatively affect the timely distribution of ARVs to dispensing sites. This combined with pharmacy staff shortages facilitate stock outs and non-adherence to HAART.
- **Diagnostic Services and Laboratory Capacity -** Chronic challenges within the transportation system are major deterrents to the successful processing of CD4 samples as the sample is fragile and requires processing within 24 hours. Non-adherence to laboratory monitoring guidelines also results in sub-optimal patient care. Additionally, ARV resistance surveillance is not yet established.
- **Stigma and Discrimination -** The impact of stigma and discrimination on key populations prevents many persons from getting tested for HIV, 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 HIV infected persons for TB has been limited and is difficult to monitor. There is also inadequate follow up of TB contacts and individuals completing therapy in communities. The diagnostic capacity for TB remains sub-optimal and centralized with limited surveillance for multi-drug resistant TB.
- **Retention on ART.** The survival rate among patients started in 2010 was 75%, a significant decline from previous assessments of this indicator. This decline was largely due to patients defaulting from care. Review of case management practices at treatment sites suggests the need for urgent strengthening action if the target for ARV access is to be met and sustained. A systematic follow-up process is required.

Impact Alleviation

In 2010, 23 treatment sites were providing multidisciplinary care in Jamaica. Treatment and care staff consist of physicians, nurses, adherence counsellors, social workers, PLHIV liaison officers, laboratory staff, nutritionists, pharmacists, clinical psychologists and positive prevention nurses. The care and support available to those who were infected or affected by HIV, were augmented through the assistance provided by key impact alleviating strategies outlined below.

Targeted Community Interventions

The prevailing negative social conditions of the communities targeted were significantly associated with the low socioeconomic status of the community members. Empowerment fairs were found to be a successful means of facilitating social inclusion. These empowerment fairs were held in partnership with various agencies that were able to provide individuals with the necessary documents to facilitate access to social services and employment opportunities as well as numerous opportunities for acquiring marketable skills.

Some of the agencies that participated in many of the empowerment workshops held across Jamaica include:

1. HEART TRUST NTA, which provided information about the various skills building programmes offered by their organization and allowed persons to be registered.

2. National Youth Services, which registered persons for entry into their job placement programme.

3. Registrar General Department, which registered persons for birth certificates and provided information on the process for acquiring marriage and death certificates.

4. Ministry of Social Security, which registered persons to receive their National Insurance Number and gave information about the National Health Fund

5. Jamaica Foundation for Lifelong Learning, which has been an important partner in providing literacy training for community members. Literacy has been identified as a major barrier to individuals in the community being able to access gainful employment.

Other activities offered at these fairs include demonstrations by private sector companies (i.e. Grace and Lasco) on how to prepare low cost nutritious meals, blood pressure and blood sugar checks, mental health screening and referrals for health and other services.

Positive Prevention Strategy

The implementation of the positive prevention strategy continued in 2010 and 2011 and was focused on increasing coverage and support to HIV positive persons. As part of the strategy, Liaison Officers conducted positive prevention workshops. In addition to discussing condom usage and negotiation, nutrition and adherence counseling, these

workshops also incorporated empowerment opportunities and access to income generation projects for persons most in need.

Further social support was provided by other partners such as Food for the Poor, Lasco, and CARIMED. Health care workers in the North East Regional Health Authority established a Social Welfare Committee that held fund raising activities to provide a steady supply of food, clothes and pharmaceuticals to PLHIV identified as most in need of this type of support. Support was also provided in the form of materials to start small businesses such as dressmaking or farming, back to school assistance for children infected or affected by HIV, assistance to adult PLHIV who were interested in literacy classes, CXC classes, and vocational learning among others. Several PLHIV also benefited from income-generating grants that were funded by the National AIDS Committee (NAC).

Income-generating Grants

In 2010 and 2011, the partnership with the NAC continued as the NAC entered the 2nd and 3rd years of a three year US$100,000/year grant from the Global Fund. The Global Fund grant, through the NHP, sponsored an income generating grant, which was implemented by the NAC. Essentially, the NAC provided small grants to assist PLHIV in setting up or expanding income generating projects or to seek training or certification of skills. Despite these activities, it is clear that adequate support networks will be established only with further strengthening of partnerships between other related Ministries of the Government (e.g. Ministry of Labour and Social Security), NGOs, FBOs, the private sector and other members of civil society.

The Children of Faith, an NGO, also provided support for persons living with or affected by HIV or AIDS through the provision of income generating projects, in particular for chicken rearing, retail clothing, farming and cosmetology. The organization aims to improve the lives of children infected with or affected by HIV. Consequently, grant recipients must come from households that include children. The organization, which originated in St. James, extended to the north-east region during 2010.

In addition, through partnerships with organizations such as the Rural Agricultural Development Agency (RADA), Child Development Agency (CDA), HEART Trust NTA, Registrar General Department, Kiwanis Ocho Rios and the Inland Revenue Department, household heads were provided with the opportunity to improve the standard of living of their families through access to remedial education, skills training, social services and technical expertise in income generating areas.

National Composite Policy Index – Trend Analysis

The National Commitment and Policy Instrument (NCPI) questionnaire is divided in two parts: Part A, which was administered to government officials, and Part B, which was administered to representatives from civil society organizations, bilateral agencies, and UN organizations (Table 4).

Part A		Part B	
Tool Sub-section	**# of Persons interviewed**	**Tool Sub-section**	**# of Persons interviewed**
I. Strategic Plan	8	I. Civil Society Involvement	16
II. Political Support	6	II. Political Support and Leadership	12
III. Human Rights	4	III. Human Rights	16
IV. Prevention	8	IV. Prevention	15
V. Treatment, care and support	8	V. Treatment, Care and Support	9
VI. Monitoring and Evaluation	7		

Table 4: Number of Person who completed each Sub-section of Part A and B of the NCPI in 2012

This trend analysis compares the current findings to results from previous years and is detailed in Appendix 1.

The tool uses three scales to rate the questions as seen below.

Rating Scale 1 to 10: 1 representing the lowest possible rating and 10 representing the maximum rating.

Rating Scale 1 to 5: 1 representing the lowest possible rating and 5 representing the maximum rating.

Rating Scale 1 to 4: Where a rating of 1 represents strongly disagree, 2 represents disagree, 3 represents agree, 4 represents strongly agree.

Analysis by Section

PART A

Human Rights

The 2011 NCPI indicated that Jamaica has non-discrimination policies that address key populations with the exception of prison inmates, SW and transgendered people. The Charter of Rights and Fundamental Freedoms and the revised Civil Service Order are the laws that provide protection for the general population on discrimination issues. However, the country has laws and regulations that present obstacles to effective HIV prevention,

treatment, care and support for key populations and vulnerable groups such as MSM, SW, inmates, injecting drug users, women and girls.

Strategic Planning

Strategic planning and multi-sectoral involvement is strong in Jamaica's HIV response with a rating for strategic planning efforts on HIV programmes moving from 7 to 9 from 2003 to 2009. However, a slight decline was noted in 2011 to 8. The National Strategic Plan (NSP) addresses most at risk populations as well as high-risk settings and cross cutting issues. However, injecting drug users (IDU) are not addressed as surveillance data do not suggest that IDU contribute in any significant way to the HIV epidemic in Jamaica. Surveillance data has pointed to the impact of other drug users, largely crack/cocaine users, and these populations are addressed in the NSP. In 2011, all sectors were included in the multi-sectoral strategy with an earmarked budget for their HIV-related activities.

Political Support and Leadership

Despite positive reviews of the HIV response by heads of government and other high officials and a strong multi-sectoral response, perception of the political support and leadership towards HIV in Jamaica has not changed much since 2003. Antiquated laws present obstacles to vulnerable populations such as adolescents, MSM, SW and inmates, from accessing prevention and treatment services. The existing political framework has also been implicated in contributing to the stigma and discrimination faced by MSM. However, in 2010 the Charter of Fundamental Rights and Freedoms was introduced, the Sexual Offences Act was amended and work on revising the Public Health Order has commenced. The rating for political support for HIV/AIDS programme increased from 7 in 2005 to 8 in 2007 and has remained constant at 7.

Prevention

Findings from the NCPI indicate that perceived weaknesses in the prevention efforts are directly related to the barriers encountered through the political arena where policies, regulations and laws impede their full reach to key populations. Notwithstanding these challenges, ratings for policy efforts in support of prevention have seen incremental increases from 4 in 2003 to 7 in 2007 but in 2009 experienced a decrease in rating to 6. However, 2011 saw an increase in ratings to 7. The overall rates for efforts in the implementation of HIV prevention programme saw incremental increases from 6 in 2003 to 9 in 2009 with the exception of 2011 that saw a rating of 8.

Treatment, Care and Support

The treatment, care and support arm of the country's response has improved steadily since 2003 to 2007 according to the NCPI. However, 2009 and 2011 have seen decreases in ratings of efforts in care and treatment of HIV from 9 in 2009 to 7 in 2011. Programme challenges that accounted for the decrease in rating are related to stigma and discrimination towards key populations in health care settings, limited involvement of private practitioners in the management of PLHIV, and challenges in reaching MARPs to conduct HIV testing. Nonetheless, several adjunct treatment, care and support interventions were implemented including the introduction of PLHIV liaison officers and

psychologists to assist in the care and support of PLHIV. Key achievements noted were the scale-up of testing and treatment in 2009 and the expansion and improved capacity of laboratories in 2011. In addition to increased laboratory services, ARV access increased with research being undertaken to improve understanding of drug resistance.

Ratings of interventions for OVC, however, have fallen in 2009 and 2011. There are no policies in place to address the additional HIV related needs of OVC, and not enough is known about interventions, and the presence or absence of actions plans to warrant high ratings. Hence, rating in 2003 were 6, 7 in 2005, 8 in 2007, 7 in 2009 and 5 in 2011.

Monitoring and Evaluation

Monitoring and Evaluation (M&E) has seen steady increases from 2003 – 2009 but ratings for 2011 decreased. With ratings of 6 and 7 in 2003 and 2005 respectively, it increased to 9 in 2007 and 2009 but fell to 8 in 2011. Key achievements noted in M&E include establishment of one National M&E plan, publication of the M&E Plan and Operations Manual, strengthening of electronic databases, existence of a functional M&E unit with a working group (MERG) that met regularly in 2010 and 2011, and implementation of mechanisms to ensure that key partners submit their M&E reports to the unit for data sharing purposes. In 2011, concerns exist, however, that the health information system is fragmented and timely reporting of M&E data from sub-national level impact on the ability to use M&E data for programme planning and development. Limited stakeholder computer literacy and access require on-going training and funding to facilitate a functional M&E system.

PART B

Human Rights

Ratings for efforts in implementing policies, laws and regulations for Human Rights have remained relatively lower than other areas over the period. Although in 2005 interviewees responded in the affirmative to having laws and regulations that protect PLHIV against discrimination, and no to the presence of laws and regulations that present obstacles to effective HIV prevention, their responses in 2007 and 2009 were reversed. However in 2011, changes in the legislative /policy environment yielded affirmative responses for both. In addition, affirmative responses were given to whether the country has a general non–discrimination law that came into effect in 2010.

Fluctuation in ratings was noted with regard to policies, laws and regulations in place to promote and protect human rights with a rating of 6 given in 2007 and 2009, as compared to 5 in 2005 and 2011. The decrease can be explained by respondents discomfort with the slow pace of legislative reform and the increase number of policies that exist instead of laws. These policies lack implementation plans. An incremental increase was seen in regards to efforts to enforce the existing policies, law and regulation from 3 in 2005 to 5 in 2009 and 2011

Civil Society Participation

In 2005 the extent to which civil society representatives have been involved in planning and budgeting processes for NSP was rated at 7 (out of 10), which then decreased to a rating of 3 (out of 5) in 2007[1]. In 2009, the NCPI had introduced independent measures for planning and budgeting with the inclusion of "reporting" as another rated programme element. From 2009 to 2011 these areas saw stable ratings of 4 and 3 for planning and budgeting respectively, with the exception of reporting, which increased from 3 in 2009 to 4 in 2011. The justification provided for the increase is that civil society spear headed the NHP Annual Review in 2011, which was considered a success.

As it relates to the extent to which civil society has made significant contributions to strengthening the political commitment of top leaders, there have been declines in ratings from 8 in 2005 to 2/5 in 2007, 3/5 in 2009 and 2011. This is attributed to a concern that civil society is not the driver of the HIV response and is too dependent on government support to advocate effectively. In 2009, NCPI included civil society's ability to access financial and technical support. Though these ratings are consistent at 3/5 in the financial support section through to 2011, technical support section saw a decline from 3/5 in 2009 to 2/5 in 2011. Civil society was split in their views regarding adequate technical support, with concern that the same organizations benefit from training opportunities.

There has been consistency from 3/5 in 2009 to 2011 regarding the civil society's inclusion in M&E related activity such as MERG participation and use of local data. However an increase was noted from 3/5 in 2009 to 4/5 in 2011 regarding civil society's inclusion in developing M&E plans. Respondents in 2011 reflected increased involvement in developing M&E plans particularly those civil society groups and organizations with the capacity to contribute to the process. The overall component rating of efforts to increase civil society participation was consistent at 8 for the years 2005 and 2007 but fell in 2009 to 7, however saw an increase to 8 in 2011. This increase is linked to improved civil society involvement noted during the development of the NSP 2012- 2017 and the increase in civil society's participation in the CCM.

Prevention

In 2011 respondents agreed that majority of people in need have access to most prevention programme areas such as condom promotion, MTCT, HIV counselling and testing, prevention for out of school young people, workplace prevention programmes, IEC on risk reduction and stigma and discrimination, risk reduction for sex workers, school based HIV education for young people, and universal precautions. Blood safety and PMTCT received strongly agree responses that the majority of persons in need have access to these services. However, for areas such as harm reduction, reproduction health services including STI prevention and treatment and risk reduction for men who have sex with men and intimate partners of key populations respondent disagreed that the majority of persons in need have access to these services.

Efforts in the implementation of the prevention programme increased from a rating of 6 in 2003, 7 in 2005 to 8 in 2009, however, dropped to 6 in 2011. The decline in rating is

[1] Ratings from 2007 are out of 5.

related to changes in World Bank ratings that categorize the country as middle-income and hence limit financial support for prevention initiatives through the Global Fund. Other concerns are linked to limited programme reach and coverage of key populations with the proportion of persons who are unaware of their HIV status still being high.

Treatment, Care and Support

Ratings for efforts in care and treatment moved from 6 in 2003, to 9 in 2005, and then ratings trended downward to 8 in 2007 and 2009, and then further decreased to 7 in 2011. In 2011 respondents commented that care services are deficient and hence accounted for reduced ratings. However, rating of effort to meet the needs of OVC[2] showed an increased rating from 2003 to 2005 and was consistent into 2007 while 2009 saw a decrease in rating to 5, with a further decrease to 4 in 2011. Policies and strategies to address the additional HIV-related needs of OVC need revision as strategic plans have expired and new priorities and interventions are needed to address the prevailing needs of OVCs.

Political Support and Leadership

The government has involved PLHIV, MARPs and other vulnerable groups in HIV policy design and programme implementation. Evidence of this is noted through PLHIV and other vulnerable groups' membership on the CCM. However, the involvement of lesbians, gays, bisexuals, and transsexuals (LGBT) in leadership matters remains an area for improvement.

Financing the National Response to HIV

The national HIV response in Jamaica is primarily financed through a loan agreement with the International Bank for Reconstruction and Development (IBRD/ World Bank), grants from the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), the United States Agency for International Development President Emergency Plan for AIDS Relief (USAID PEPFAR), and the Government of Jamaica (GoJ). GFATM provides the principle financial support for Jamaica's ARV programme. Round 7 Grant of USD39, 991,051 started on the 15 November 2010 and the planned end is 31 July 2013.The World Bank second HIV & AIDS Project for a loan of USD10m is set to close on Nov 30, 2012 and, for the purposes of the report, has been classified as GOJ expenditure in line with guidance from the Global Fund. The USAID grant value is USD1,176,309 with the GoJ contribution required of USD363,087. The completion date for the project is September, 30, 2014.

In 2011, with the assistance of UNAIDS, the National AIDS Spending Assessment (NASA) was conducted in Jamaica. The methodology used was based on the Guide to Produce National AIDS Spending Assessment, May 2009, which was produced by the Joint UN Programme on HIV & AIDS, WHO and World Bank.[2]

[2] Part B TCS questions 1.2 and 3 are the same. As such question 3 was interpreted as being related to OVCs.

Jamaica's NASA covered two financial years: April 2009 to March 2010 and April 2010 to March 2011. The aim of NASA is to develop a strategy involving multi-sectoral and multi-level key partners to track HIV-related spending, to contribute to the implementation of a methodology for systematic monitoring of HIV/AIDS financial flows at national and regional level, and to build national level and regional capacity to conduct such monitoring.

Survey instruments were sent out to 65 HIV stakeholders in Jamaica that included donors, financial agents and providers of services. Of these, 28 surveys were completed (response rate 44%). This, however, represents the majority of HIV-related expenditure as the NHP is the major agent for the distribution of donor funding from the Global Fund, World Bank and USAID.[3]

A summary of three categories of NASA is provided: 1. HIV Expenditure by Financial Source, 2. HIV Expenditure by Service Providers and 3. HIV expenditure by programme area. The detailed report is available at: **www.nhpjamaica.org**.

Jamaica's Expenditure on HIV for the period 2009 and 2010

HIV Expenditure by Financial Source

HIV-related spending by financial Source (funders) in Jamaica for the period 2009 and 2010 is shown in Table 5 and Figure 8 below. During 2010/2011, public spending increased by 3.6 percent while international spending decreased by a corresponding 3.7 percent. Private sector expenditure remained constant. The global fund grant was the main funding source between 2009 and 2011, accounting for more than 50% of HIV expenditure.

HIV & AIDS Expenditure by Financial Source	JMD 2009/10	JMD 2010/11
Total Spending	1,321,746,436	1,276,015,167
Public:	299,096,806	334,859,307
Percent	22.6%	26.2%
International:	1,018,649,631	937,155,860
Percent	77.1%	73.4%
Private:	4,000,000	4,000,000
Percent	0.3%	0.3%

Table 5: HIV Expenditure in Jamaica by Financial Source, 2009 and 2010

[3] Ibid

JMD = Jamaican Dollars

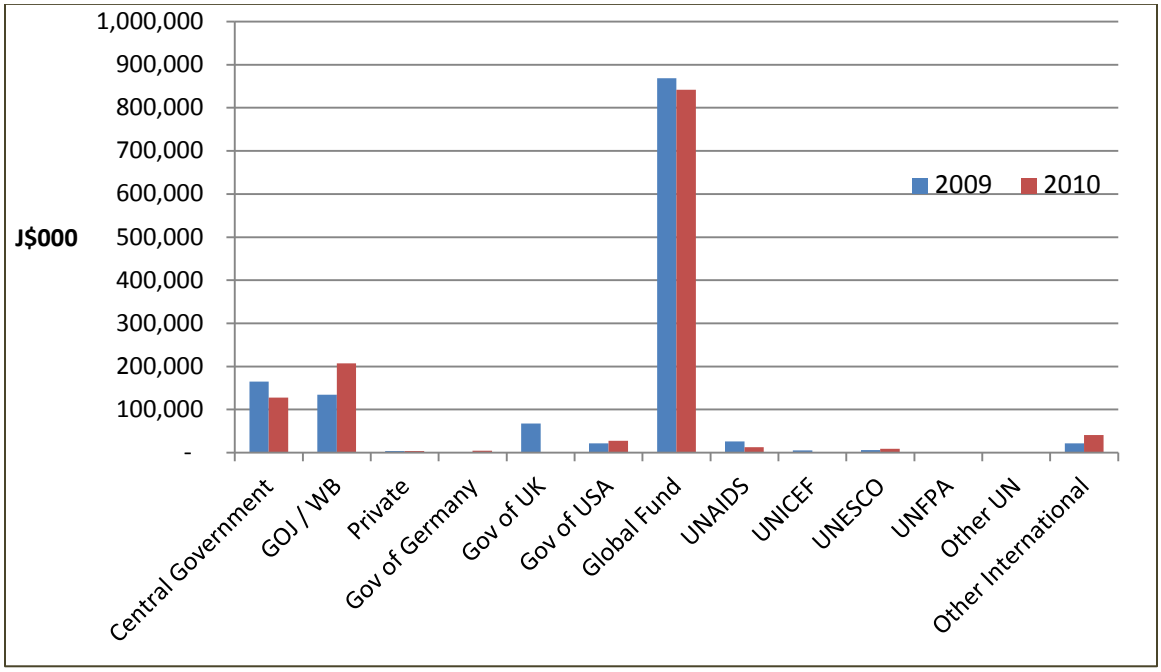


Figure 8: HIV Expenditure in Jamaica by Financial Source, 2009 and 2010

By programme area, the Global Fund grant was also the primary source of funding for all areas except HIV related research (DFID and UN Joint Team in 2010 and 2011 respectively). Specifically, Global Fund accounts for just over 84% of expenditure in the prevention programme, 57% of treatment and 51% in programme management. The Government of Jamaica's (GOJ) expenditure on the HIV response is highest under the Treatment, Care and Support component, accounting for 30% of expenditure in 2009 and 25% in 2010. This is likely to be an underestimate of the GOJ expenditure as the NASA instrument does not capture data on inpatient care and services, which is substantial. Nevertheless, Jamaica's NASA demonstrates the significant challenge in sustaining the national response to HIV in a climate of dwindling donor funding.

HIV Expenditure by Service Provider in Jamaica for the period 2009 and 2010

The health sector is the primary service provider spending on HIV services. Government Ministries' expenditure on HIV during 2010 dropped by JMD141, 860,396, which resulted in civil society being the second largest service provider spending on HIV-related services in 2010 (Table 6 and Figure 9).

HIV Expenditure by Service Providers	JMD 2009/10	JMD 2010/11
Public Providers		
Health Sector	827,423,392	870,440,425
Government Ministries	248,924,424	107,064,028
Bilateral and Multilateral and International Agencies:	26,412,425	6,808,051
Civil Society	218,015,529	269,659,045
Private:	-	-
CHART	970,666	10,644,827

Table 6: HIV Expenditure in Jamaica by Service Providers, 2009 and 2010

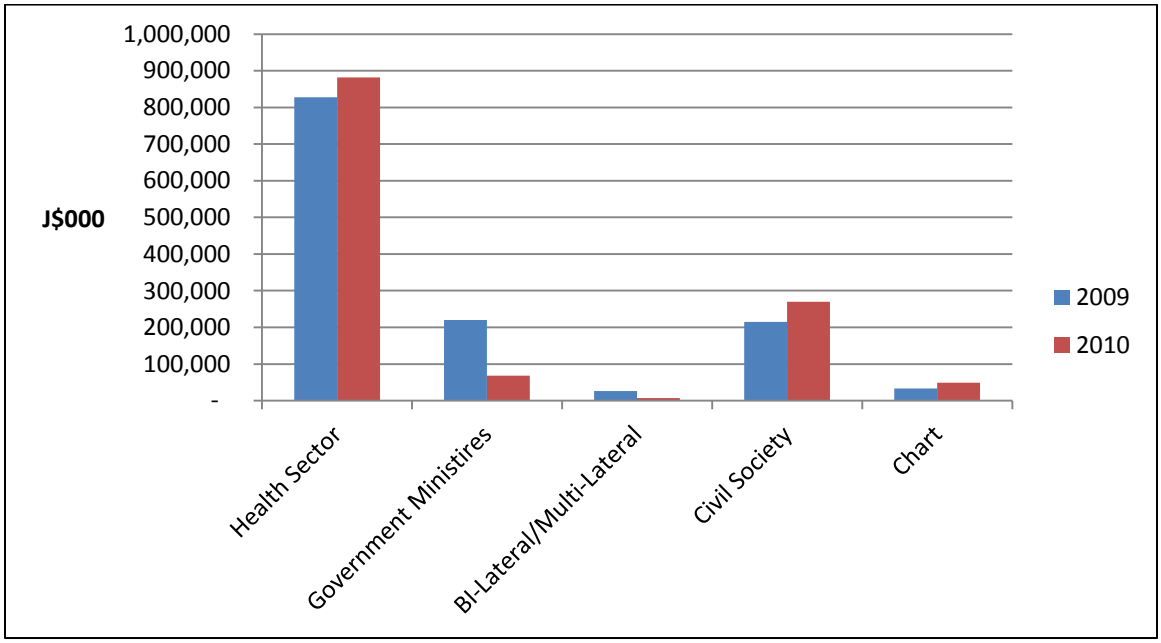


Figure 9: HIV Expenditure in Jamaica by Service Provider, 2009 and 2010

HIV Expenditure by Programme Area and Funding Source

The NASA conducted in Jamaica utilized most of the AIDS Spending Categories as defined by the 2009 National AIDS Spending Assessment (NASA): Classification and Definitions. In an effort to capture all in country spending, new AIDS Spending Categories were developed that reflected unique spending categories.

In the area of prevention, in 2009 the majority of the expenditure was directed at information and educational material (IEC). However, this reduced by over half in 2010 as the focus moved to VCT, expenditure related to key populations and youth. Expenditure on MSM related prevention programmes remained stable for both periods.

Under the treatment programme, expenditure was greatest on ARVs and outpatient care while advocacy was the main activity funded under the enabling environment component. Expenditure by programme areas are summarized in Figures 10 to 13.

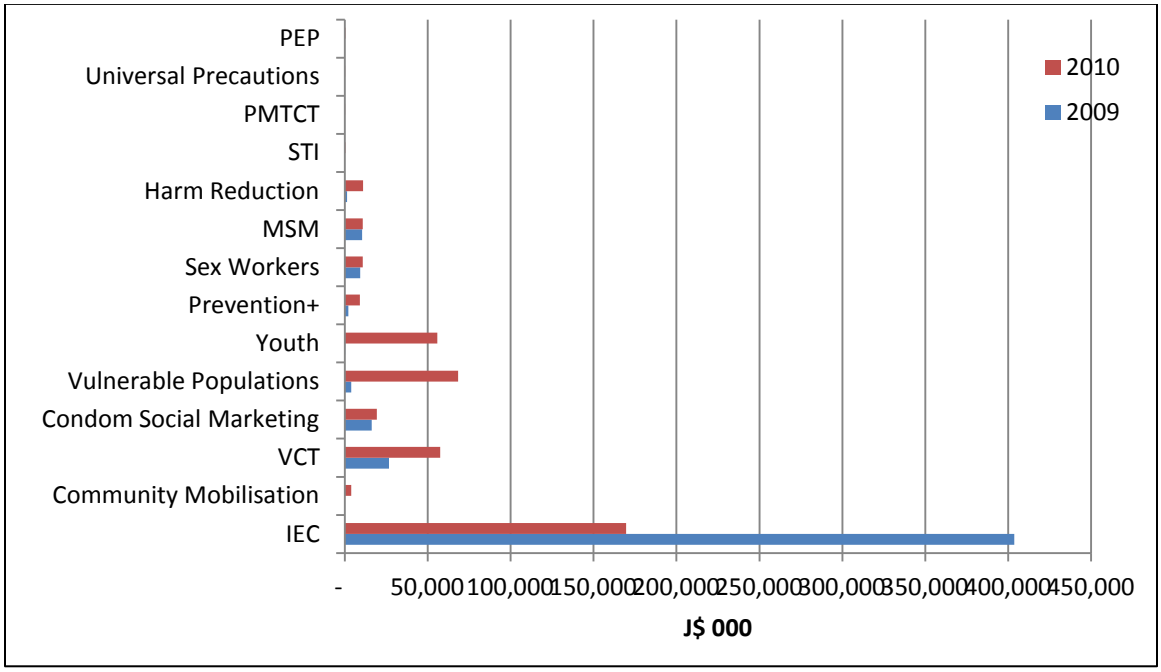


Figure 10: HIV Expenditure on Prevention activities in Jamaica, 2009 and 2010

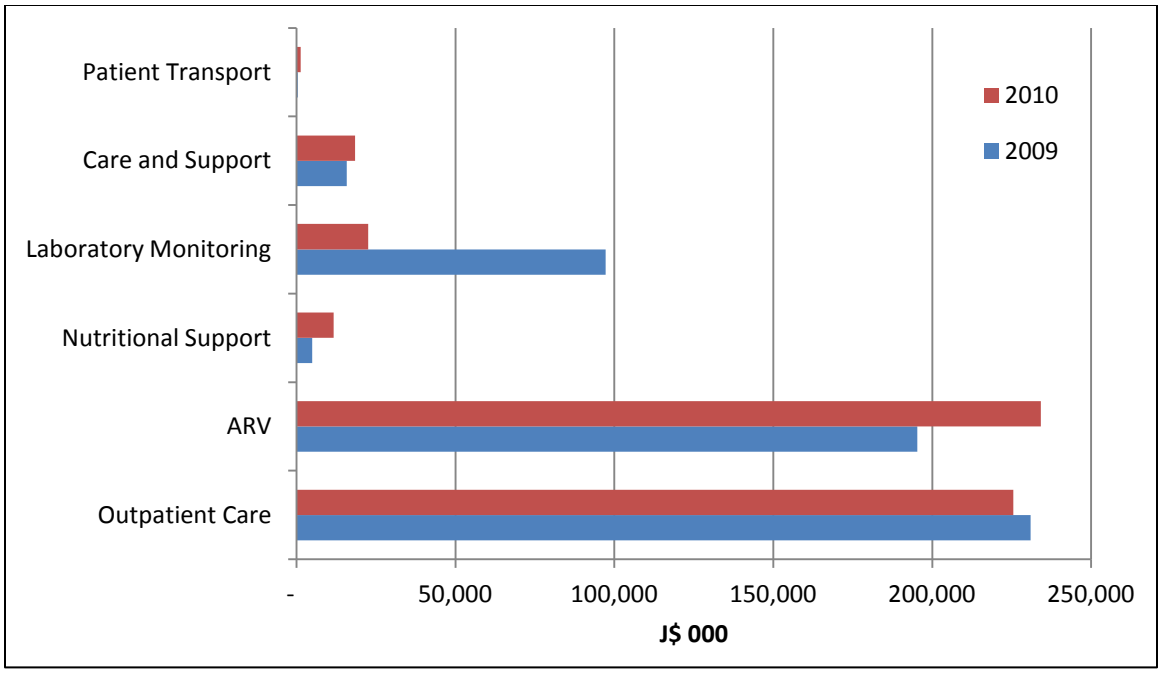


Figure 11: HIV Expenditure on Treatment, Care, and Support Activities in Jamaica, 2009 and 2010

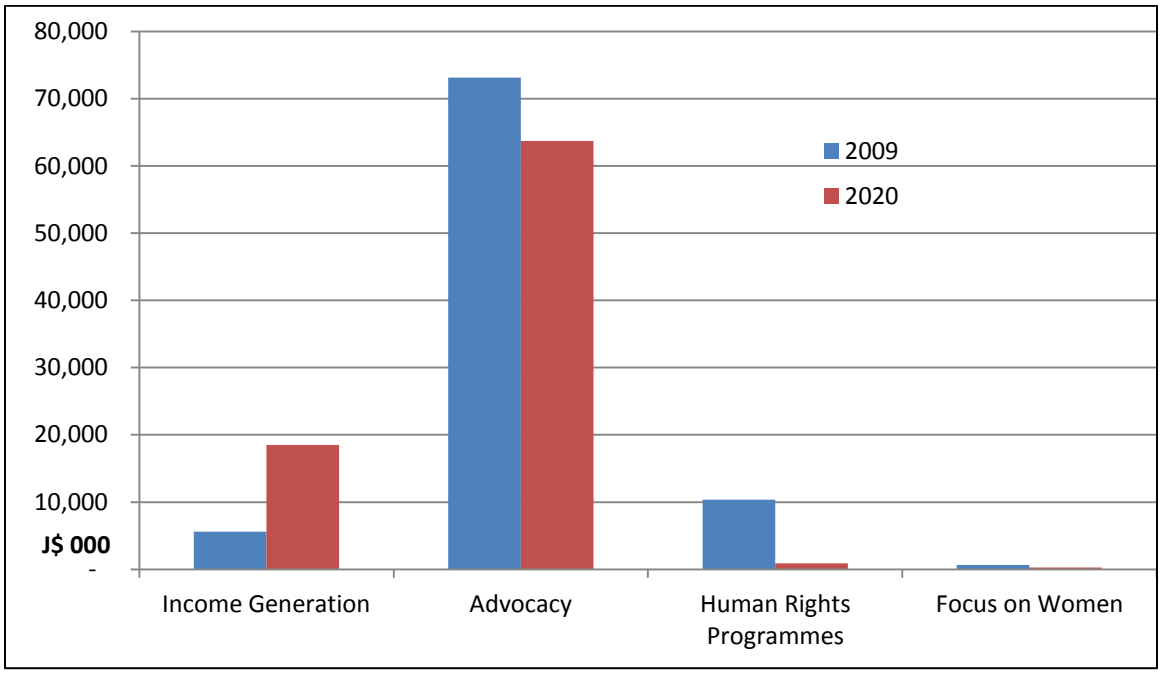


Figure 12: HIV Expenditure under the Enabling Environment and Human Rights component in Jamaica, 2009 and 2010

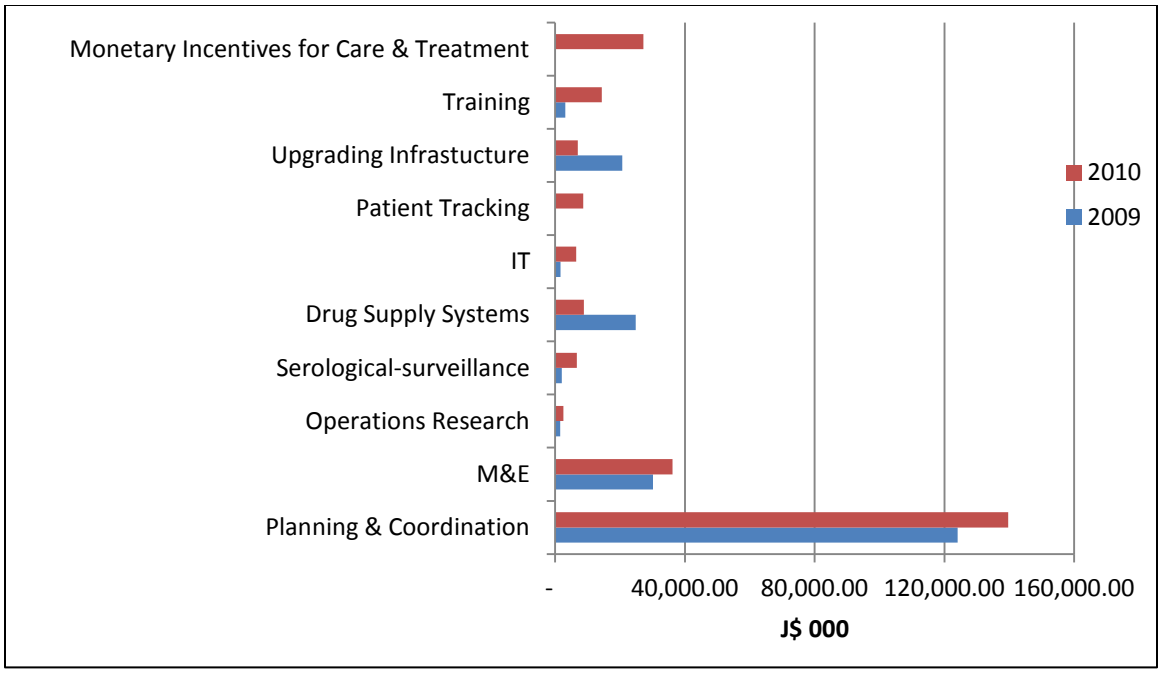


Figure 13: HIV Expenditure under the Empowerment and Governance component (including M&E) in Jamaica, 2009 and 2010

Way forward

The NASA instrument provides a useful tool to track in-country resource flow in the national HIV response. Discussions will follow with UNAIDS to secure financial assistance to implement the NASA on a regular basis. In addition, the findings will be reviewed at various stakeholder meetings along with other new data, such as the distribution of new HIV infections, and will provide a basis for improving resource allocation in deficient areas of the response. Further consultations with stakeholders in the national response are essential to obtain buy-in to the process and subsequently, improved response rates. This will ensure completeness and reliability of the process.

Best practices

Name of Project	Quality HIV/AIDS Prevention and Treatment Services to Hearing Impaired MSM in Jamaica
Organization	Jamaica AIDS Support for Life (JASL)
Area	Prevention
Timeline	May 2011-2012 April
Name of Funder(s)	amfAR MSM Initiative
Beneficiaries	Hearing Impaired Community
Project Objectives	1. Maintain the existing Deaf MSM support group in Kingston and create four new groups in Mandeville, Savannah-la-Mar/Westmoreland, Montego Bay and Brown's Town (approximately 8 persons per group) 2. Increase the number of Deaf MSM routinely (at least bi-annually) accessing health services including HIV testing by 50% 3. Assist Deaf MSM accessing HIV and AIDS services at their local health centres
Outcomes/Outputs	1. Monthly support group meetings have been held in 5 communities - Kingtson (JASL), Montego Bay, Savanna-la-Mar, Mandeville (Manchester) and Brown's Town at St. Christopher School for the Deaf (St. Ann) 2. Project Coordinator and Project Assistant have been routinely available for support to deaf clients at all JASL clinic sessions. 3. The frequency of clinical sessions increased from twice monthly to 4-5 times per month. 4. Hearing impaired client support is provided in these sessions, as needed and as human resources are available. 5. Another factor is sporadic attendance from the hearing impaired community.
Evaluation/Results	The implementation of the program has deepened JASL's knowledge and understanding of deaf psychology and culture. Through the programme it has sharpened the sensibilities of all staff towards the unique challenges of hearing impaired MSM, and those who have additional challenges such as HIV positive status and involvement in sex work. Healthcare workers and other programme staff employed to JASL have also been rendered much more sensitive to this often neglected sub-set of MARPs. Our clients now benefit from a wider and more robust social support system with several dimensions - clinical, social, professional and virtual (through social media). With the engagement of their families they are also gradually benefitting from greater levels of acceptance.

	Through training and support group sessions they have been sensitized on critical human rights issues, therefore empowering them to seek and insist on fair treatment when they seek services from private or public agencies. Clients have been also able to extend their national network of contacts by being allowed to attend meetings outside of their own town/city, and to meet persons with similar needs and interests. One major benefit is also a better understanding of hearing people through mixed sessions and with that the transfer of bankable leadership skills such as facilitation and the management of small projects. 1. 51 deaf attendees are served through support group meetings monthly. 2. 82 % of deaf support group attendees have consistently attended 4 and 8 meetings 3. 21 deaf MSM attending meetings 4. 29 non- MSM deaf were also engaged in the meetings (14 Sex Workers, 2 Women who have sex with women, 11 heterosexual males and 4 heterosexual females) 5. 9 MSM, 2 MSM SWs and 5 deaf PLHIV were referred to the JASL clinics. 6. 22 deaf support group attendees accessed VCT 7. 1230 male condoms, 52 female condoms and 94 lubricants were disseminated support group attendees
Lessons Learned	1. Secure sponsorship of safe, secure, private spaces to host support group meetings in all 5 locations. 2. Pursue a parallel Positive Health, Dignity & Prevention programme for PLWA, funded separately and with the provision of stipends. 3. Lobby the local health authorities to assign staff to target hearing-impaired community, as a group with unique needs within their MARPs classification. 4. Take the MSM support group outside of JASL's Kingston space. 5. Lobby for funding of a Peer Educator/Influencer program among the hearing-impaired community to facilitate deeper penetration and to reach those who will never publicly self-identify as MSM. 6. Include Town Hall/community meetings on HIV/AIDS issues, which utilizes the leadership skills of persons within the hearing-impaired community. This would greatly enhance the perception of capabilities within the deaf community and pave the way for greater respect

	and wider acceptance of deaf MSM in the wider community.

Name of Project	MARPs-friendly Clinical Services
Organization	Jamaica AIDS Support for Life
Area	Treatment, Care & Support
Timeline	Eight (8) months
Name of Funder(s)	Govt. of Jamaica – Ministry of Health
Beneficiaries	Marginalized, Out of School and Unattached Youth from several vulnerable communities of the Kingston inner city as well as high school students from a special target of Three (3) schools (Identified by the ministry and ASHE).
Project Objectives	1. To enable greater access to quality information, treatment, care and support to people infected and affected by HIV and AIDS with an emphasis on the most marginalized 2. To provide weekly medical services via a physician and nurse practitioner, support groups, adherence counseling, VCT, home and hospital visit, distribution of care packages and positive prevention workshops at times convenient to the clients including evenings and Saturdays.
Evaluation/Results	In 2011 the 3 JASL clinics held 143 sessions with medical doctors and nurses serving 939 clients. 35% of attendees were MSM, 29% PLHIV and 15% SW. In addition, 533 ART adherence counseling sessions were conducted and 434 general counseling sessions. A total of 1464 VCT sessions were delivered of which 3% received positive results. MSM made up 54% of the total positives; 69% of those testing positives were males and of these 79% were MSM. Based on the analysis of the clinic data, efforts were made in prevention to increase efforts with the MSM community.

Name of Project	Empowerment and Engagement of Sex workers to combat HIV in Jamaica
Organization	Sex Work Association of Jamaica (SWAJ)/ Jamaica AIDS Support for Life (JASL)
Area	Prevention & Enabling Environment
Name of Funder(s)	UNFPA
Beneficiaries	Male and female Sex Workers
Project Objectives	1. To establish the Sex Work Association of Jamaica

	2. To build sex workers capacity to deliver prevention services and create an enabling environment for SWs
Outcomes/Outputs	1. Twelve SWs from three of the four health regions trained in HIV Peer Education, Advocacy, Managing Conflicts, Time Management, Attitude, Deportment and Demeanour. 2. Four Master Peer Educators given in-depth training in programme planning and management along with Monitoring and Evaluation and HIV VCT. 3. Twelve SWs were deployed as Peer Educators.
Evaluation/Results	With the engagement of the 12 SWs, mapping of SW sites and classification of SWs in the four regions were conducted and results allowed for a total of 1500 SWs reached with HIV prevention messages, services and safer sex commodities. 120 SWs linked to multiple other social services. 12 Police Officers (different ranks) were trained in Human Rights and issues of SWs and the law. Organizations made new discoveries on the lifestyles, risk-factors and jargon used in programme design and delivery.
Lessons Learned	1. Empowerment and engagement of SWs in service-delivery is an effective strategy to reach the wider population. Buy-in and ownership of HIV programme outputs and deliverables is ensured. Participatory-approaches proved integral in encouraging social and behavioural changes among SWs. The population is complex. There is need for more research to understand the sex work landscape specifically around transactional Sex among youth, male SWs, transgender and the disabled.

Organization	Jamaica Youth Advocacy Network (JYAN)
Area	Enabling Environment
Timeline	January 2010 – December 2011
Name of Funder(s)	Advocates for Youth
Beneficiaries	Jamaican youth, including YPLHIV, students, MSM, among others
Project Objectives	• Increasing meaningful youth participation in policy and decision-making bodies relevant to sexual and reproductive health and rights and HIV/AIDS programmes for adolescents and youth • To promote universal access to prevention, treatment, care and support for adolescents and

	youth in schools, particularly those who are most at risk. • To increase the visibility and advocacy of Jamaican youth in the global HIV and AIDS response.
Outcomes/Outputs	• Trained eight young people from diverse backgrounds in advocacy and lobbying, US foreign policy, and sexual reproductive health and rights. • Hosted Jamaica's first Youth Universal Access Consultation with Technical assistance from UNAIDS and Caribbean Vulnerable Communities Coalition (CVC). • World AIDS Day 2011 with Jamaica Red Cross at Emancipation Park (Kingston) • Display booths and presentations at the University of Technology (UTECH) and the International University of the Caribbean (IUC) • Represent Jamaican youth on a number of committees
Evaluation/Results	• JYAN is the leading youth-led organization in Jamaica and the wider Caribbean within the AIDS response. • Developed the "*Youth Consultation on Universal Access to HIV Prevention, Treatment, Care & Support for Young People in Jamaica Youth"* Call to Action which was disseminated to a wide range of stakeholders through the Gender Technical Advisory Team at MOH with the Political Declaration on HIV/AIDS signed by the Prime Minister and Opposition Leader. • Member of Gender Technical Advisory Group on HIV, Delegation of Developing Country NGOs to the Global Fund Board, 1st Vice Chair – Jamaica Country Coordinating Mechanism, Monitoring & Evaluation Reference Group (MERG), National HIV and AIDS Strategic Plan committee, among others • Discussed and provided recommendations for greater inclusion of HIV/AIDS and Comprehensive SRHR information and services in the National Youth Policy and The Healthy Lifestyle and Family Education (HFLE). • Distributed over 2,500 condoms and lubes following several comprehensive safer sex education outreach • Hosted the Yute X 2010 Conference which provided a platform for discussion with over 300 adolescents and youth as well as adult partners on HIV and SRH • Lobbied Congressmen and women, Senators, Office of the Global AIDS Coordinator and other stakeholders in Washington DC on US foreign

	policy with regards to family planning, reproductive health, and HIV.
Lessons Learned	• Youth living with disabilities are often ignored as living with HIV or affected by HIV and AIDS, therefore little or no services are provided to this group • Youth Advocacy provides a platform for active youth participation and inclusion with the HIV/AIDS response • Effective and comprehensive sex education sessions are paramount before distribution of condoms and lubricants. • There needs to be an increase in youth friendly health services as a prevention and care response to the HIV and AIDS epidemic among youth in Jamaica. • Effective partnership with both government and civil society is effective in building the capacities of youth organizations and strengthening the AIDS response

Organization	National HIV/STI Programme
Area	Enabling Environment & Human Rights Component
Timeline	2011-Present (ongoing)
Name of Funder(s)	USAID
Beneficiaries	General Population; Workplace
Outcomes/Outputs	In partnership with the Jamaica Business Council on HIV/AIDS establish and formalize a Private Sector HIV/AIDS Foundation to mobilize and expend funds for HIV/STI related initiatives and to sustain Jamaica's national HIV/STI programme. $1billion target established.
Evaluation/Results	Private Sector HIV/AIDS Foundation established Buy in and support from some private sector organizations Monetary contributions towards the foundation
Lessons Learned	Private sector involvement is critical in the sustainability of the national HIV/AIDs response. JaBCHA is in a strategic position to engage the private sector and as such has been able to mobilize funds and support for the foundation. Establishment of the foundation

Major challenges and remedial actions

Progress Made on Key Challenges

Major challenges reported in 2010 and their remedial actions are summarized below. Details of their implementation are documented throughout the Country Report.

Access to Most at Risk Populations (MARPs). The partnerships formed through the conduct of the 2007 behavioural survey of MSM in Jamaica laid the groundwork for the expansion of prevention programmes in this population. 15,943 contacts with MSM were made for delivery of site based prevention interventions. A total of 453 MSM have been tested for HIV and 567 MSM were trained as peer educators.

Positive Prevention. The positive prevention strategy was refined to include the key principles of Positive Health, Dignity and Prevention. The strategy provided increase coverage and support to HIV positive persons. Regional clinical psychologists, positive prevention nurses and a physician were added to the cadre of staff dedicated to implementing this strategy.

Capacity building in M&E. A number of training and capacity building activities were implemented in the reporting period. In 2010, more than 100 copies of the M&E operations manual were printed and disseminated through 6 workshops. This activity was a critical step in the standardization of data collection tools, reporting timelines and data flow. Six data analysis workshops were conducted in 2011 (regional health authorities, NGOs, government ministries and NHP staff). MEASURE Evaluation also provided technical and financial support for an evaluation workshop held in April 2011.

Tackling stigma and discrimination. The system for reporting and redress of discrimination was further strengthened by the active engagement of the Public Defender, the Nursing Council of Jamaica and the Ministry of Education in the redress and resolution of cases of alleged discrimination within the public and education sectors. The indicator for tracking redress through the system was further refined and the monitoring system strengthened through a review of the data management capacity of the coordinating agency. Stigma and discrimination was also addressed through media campaigns, numerous sensitization workshops, and implementation of HIV workplace policies. In 2011, over 220 large private sector companies were reached through the HIV Workplace Programme and, of these, more than 160 had developed workplace policies and/or action plans.

Operational Research. The M&E Plan and the research agenda guided the implementation of several key surveys and special studies during this period. Completed research includes two MSM surveys, which gave insight to the behaviours that enable HIV transmission and confirmed high HIV prevalence in this key target group. Surveys have also been conducted among sex workers. Completed evaluations include an assessment of the adherence and workplace programmes. Other special studies include the determination of 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.

Scale up of treatment. Steady progress is being made in increasing access to ARV as the NHP aims to meet the target of 90% coverage. Based on programme monitoring, 9162 persons with advanced HIV (64% of persons with advanced HIV) were started on treatment by the end of December 2011. This compares to 6895 persons (49% of persons with advanced HIV) at the end of December 2009.

Challenges faced throughout the reporting period

Despite the significant progress made in Jamaica's national HIV response, several challenges continue to hamper full implementation of successful programmes.

- Stigma and discrimination continues to be a barrier to access to HIV programmes. Stigma associated with socially marginalized groups, especially MSM, remains strong and acts of discrimination are far too common. HIV infected individuals are also stigmatized, albeit significantly less than when HIV was first reported. Slow progress with social policy and legislation act counter the gains made on the ground.

- Nearly 50% of PLHIV in Jamaica are not aware of their HIV status. Many of those most vulnerable, especially MSM, are not accessing HIV prevention or treatment services or do so at a very late stage. Despite expansion of the HIV testing programme, many persons at highest risk fail to get tested for HIV. Although identified as priority groups for HIV testing, inadequate levels of provider initiated testing still occur in accident and emergency departments, among patients admitted to hospital and among persons with STI in both public and private health sectors.

- Many of those who are on treatment do not adhere adequately to ARV medication for various reasons and clinical management by some health practitioners is not at the required standard. This is likely to contribute to the emergence of HIV resistant strains.

- There have been major problems with the supply, distribution and dispensing of ARV in Jamaica during this reporting period. Public pharmacies are completely overwhelmed and patients have to wait long hours for prescriptions to be filled often having to return on another day. There are far too few pharmacies stocking ARV drugs and stock outs are common. Basic drugs for related conditions such as STI are frequently not available in the public sector and too expensive for most patients to purchase in the private sector.

- The sustainability of the programme needs to be addressed. International funding is expected to decline while Jamaica's economy continues to be challenged. The jobs of scores of prevention outreach staff, PLHIV and others are under threat as is the sustainability of the ARVs that are currently provided free of cost.

- Policy makers are reluctant to take bold steps to promote legislative changes that will provide an enabling environment and reduce the vulnerability of those most at risk. Such changes would facilitate the provision of services and practice of safer sex.

Concrete remedial actions

Jamaica's National Strategic Plan 2012 -2017 describes in detail the strategic approaches to address the issues identified based on epidemiological data, programmatic research and other indicators. Emphasis is placed on reaching MARPs, expansion of quality treatment care and support programmes, improved data utilization and protection of human rights. In this regard, some interventions that have been identified to address the challenges outlined above include:

- Revision of the MSM prevention strategy to combine quality biomedical, behavioural and structural interventions, also known as "combination prevention". Strategies will include increased use of social media and other technological tools, increased access to condoms and lubricants, increased access to comprehensive treatment care and support for HIV positive MSM, partnerships with social agencies to decrease social vulnerability (including stigma and discrimination), scale up of outreach HIV and syphilis testing, scale up of civil society response. These strategies will be guided by research including evaluation of prevention interventions.
- Legal protection and efforts to reduce stigma and discrimination will also form the foundation for increasing access to programs for MSM.
- Increased advocacy for legislative and policy reform will occur. In addition, the capacity of the police to address acts of discrimination towards PLHIV and marginalized groups will be addressed.
- Strategies to reduce stigma and discrimination in the health sector have been identified including examining issues related to privacy and confidentiality as well as greater staff sensitization.
- The cadre of health care workers will be increased to facilitate the implementation of the positive health and dignity programme. This will increase the availability of staff that can address psychosocial barriers to adherence.
- Continued training of health care workers in HIV management and expansion of HIV testing, particularly to key populations.

Support from Country's Development Partners

The National HIV/STI programme (NHP) continues to benefit from access to technical and financial support from development partners in Jamaica. This has contributed to the successful implementation of programmes, improved strategic planning and strengthened M&E including achievement of global targets. The technical interventions have facilitated the implementation of the NSP and ultimately contained the epidemic with renewed commitment to significantly reduce new infections by 2015.

Some areas of support are summarized below.

- **M&E:** Development partners have supported the development and implementation of one M&E plan and the roll out of the operational manual. Technical assistance and/or funding have been provided for studies and analyses such as the Modes of Transmission (MOT), the NASA, and the 12-components assessment of the M&E system. Development partners have also actively participated in several activities including Jamaica's MERG, development and implementation of the research agenda, surveys of key populations, planning and delivery of M&E 101 workshops and development of M&E training materials.
- **Prevention:** Support for prevention activities includes development and Peer Review of the new National Strategic Plan and coordination of the Prevention Technical Working Group. Development partners also provided technical and/ or financial assistance for gender mainstreaming of the HIV response, qualitative survey of most-at-risk youth, situational assessment of VCCT for minors, situational assessment of OVC, survey of SW and MSM, assessment of integration of Jamaica's HIV response with the National Health System and development of Positive Health Dignity and Prevention Programme.
- **The Enabling environment and Human Rights:** Support received includes development/drafting of the declaration of commitment, assisting with the planning of consultation with high level leaders, coordination and support to JNPlus to conduct PLHIV Stigma Index research, assist with the launch of JaBCHA's Private Sector HIV/AIDS Foundation and supporting GIPA capacity building programmes.
- **Treatment, Care and Support**: Support to this component included review of the HIV Management and PMTCT manuals as well as assisting with PCR data management. In addition, IDP assisted with the development of several M&E tools for the treatment programme such as databases at the NPHL for CD4 counts, an ARV costing tool, a pharmacy reporting tool and a patient intake form. Support is expected to grow over the next two years as sustainability of ARVs comes into more focus.

It has been repeatedly stated that coordination of activities of development partners is the area needing the greatest improvement. In working alongside the NHP, development partners can ensure effective use of resources through continued financial and technical assistance resulting in implementation of one NSP and M&E plan.

Monitoring & Evaluation Environment

In 2004, the NHP established an M&E Unit to track the progress of the National Strategic Plan and hence, Jamaica's HIV response. Guided by the M&E Plan, the M&E system has been implemented and has supported the national response. Despite many achievements, important gaps remain that must be addressed to achieve a fully functioning M&E system

Achievements

Some key actions taken to strengthen the M&E system in the 2010 – 2011 included:

- In 2010, more than 100 copies of the M&E operations manual were printed and disseminated through 6 workshops in each health region to stakeholders. This activity was a critical step in the standardization of data collection tools, reporting timelines and data flow. The manual was developed in collaboration with the team from Monitoring and Evaluation to Assess and Use Results (MEASURE) Evaluation, University of North Carolina.
- Six data analysis workshops were conducted in 201. Participants represented staff from each regional health authority, NGOs, government ministries and NHP staff.
- MEASURE Evaluation provided technical and financial support for an evaluation workshop held in April 2011.
- Monitoring responsibilities were integrated into Terms of Reference and Memoranda of Understanding of stakeholders.
- The information system was strengthened by modification of the HIV/AIDS tracking system to reflect new variables. Other databases were modified in 2011 to reflect changes in algorithms and protocols e.g. rapid test and treatment databases.
- In response to stakeholder requests, new modules and reports were added to the treatment database and a 2-day training workshop was designed to further support the use of the electronic ARV registry.
- NHP partnered with Clinton Health Access Initiative (CHAI) team to provide technical support to pharmacies and treatment sites with regard to strengthening forecasting and implementation of databases.
- The Country Response Information System (CRIS) was adapted to the local context, and hardware and software were distributed to stakeholders to facilitate implementation.
- Increased operational research occurred, including implementation of a national HIV research agenda through the MERG to answer key questions for programme management. Other completed research includes two MSM surveys, SW surveys, evaluations of the adherence and workplace programmes. 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

Capacity building: Many implementing stakeholders 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. Limited evaluations of interventions occur, hampering identification of cost effective approaches in the face of diminishing resources.

Partnerships: At the national level, there is a lack of clarity about the services and deliverables to be expected from the NHP. While the M&E Unit conducts a number of training workshops, the resources exist for more to occur, and there is limited coordination of M&E training between the M&E Unit of the NHP, CHART, UWIHARP and other training entities.

Databases: Many of the databases that have been developed are being used at a sub-optimal level, thereby limiting their usefulness and accuracy. Inadequate support staff exists to maintain databases at parish and organizational level. In addition, interrupted power supply, inadequate human resources and limited buy-in by stakeholders have hampered implementation of databases. Many HIV related databases are not currently linked or merged.

Data collection: 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 M&E 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: 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 epidemic 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 and often do not include key populations. 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.

Remedial Actions

In July 2011 the M&E Unit, with technical support from MEASURE, conducted a 3-day workshop with over 45 stakeholders. Stakeholders worked in assigned small groups to complete a comprehensive assessment of the national HIV M&E system using the *12 Components Monitoring and Evaluation System Strengthening Tool.* Each group identified strategies to improve on the strengths and address the gaps and weaknesses that were identified. The HIV M&E Plan, 2012-2017, is the result of this participatory process of

assessing the existing M&E system. The M&E Plan describes a number of strategies to be implemented throughout the 5 year strategic planning period 2012-2017. These strategies will 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.

To this end, specific activities that have been prioritized for implementation in 2012/2013 include:

2012

- Sensitization on the contents of Operations manual, M&E plan and MERG roles and responsibilities
- Define and establish baseline for all core indicators.
- Conduct audit of existing databases in order to develop a centralized database for all.
- Conduct communication audit
- Improve data flow and establish data system at regional health authority level
- Develop checklist & schedule of surveys and surveillance activities
- Timely review of data collection tools to ensure staff have current updated versions of the tools
- Dissemination of HIV Case Based Reporting Surveillance Manual
- Develop entity specific M&E work plans

2013

- Integrate gender component in existing M&E Training
- Formalize, develop & distribute protocol for supportive supervision
- Develop guidelines for participating in workshops: - clear objectives, selection of participants, utilization of training
- Develop user-friendly manuals for databases (basic troubleshooting etc.)
- Establish a national process for identifying research gaps relevant to the NSP and build a research agenda; Include gender analysis in the research agenda
- Coordinate research partners to ensure studies are relevant to the countries needs to provide actionable results.
- Improve information sharing- M&E tools, expectations and requirements
- Review and revise MERG work plan
- Strengthen the capacity of data entry clerk in basic analysis & promote peer to peer mentorship
- Develop data quality protocol to guarantee accuracy of data collection, entry, collation & analysis, including gender analysis
- Develop strategy to gather data from private practitioners.

References

Duncan J, Grant Y, Clarke TR et al. Sociodemographics and Clinical Presentation of HIV in Jamaica Over 20 years: A Comparative Analysis of Surveillance Data. West Indian Med J 2010; 59 (4): 409.

Figueroa JP, Duncan J, Byfield L, Harvey K, Gebre Y, Hylton-Kong T, Hamer F, Williams E, Carrington D, Brathwaite AR. A comprehensive response to the HIV/AIDS epidemic in Jamaica: a review of the past 20 years. West Indian Med J. 2008 Dec;57(6):562-76.

Figueroa P, Weir S, Jones Copper C, Byfield L, Eastman S, Hobbs M, Duncan J. High HIV rates among men who have sex with men in Jamaica despite increased prevention efforts. 2011 Caribbean HIV Conference, Nassau, Bahamas 2011.

Figueroa, 2012 (Unpublished) Draft report on Second Generation Surveillance of MSM and CSW in Jamaica

Hope Enterprises (2008). National Knowledge, Attitudes, Behaviours, and Practices (KABP) Survey: 2008. Kingston, Jamaica.

MEASURE Evaluation. Third generation surveillance of MSM and SW in Jamaica. North Carolina, USA.

Ministry of Health, Jamaica. National HIV/STI Programme Annual report 2010. Jamaica: Ministry of Health, 2011.

Ministry of Health, Jamaica. Jamaica Epidemic Update January to December 2010. Jamaica: Ministry of Health, 2011.

Ministry of Health, Jamaica. National Strategic Plan 2012 -2017 (draft). Jamaica: Ministry of Health, 2012.

Ministry of Health, Jamaica. UNGASS report January 2008 –December 2009. Jamaica 2010.

ANNEX 1: Preparation Process for Jamaica's Global AIDS Response Report, 2012

This report draws heavily on the NSP 2012-2017 (Ministry of Health, 2012) and the accompanying M&E Plan, which were developed through extensive consultative processes. The M&E plan describes monitoring tools and special studies implemented by stakeholders to inform the indicators. The Draft Progress Report was presented to stakeholders to gain consensus on the completed inputs. Participants included 50 key Government and civil society stakeholders, bilateral agencies including UN. The National Validation Meeting was held on March 26th, 2012 and included working groups organized around each target. The compiled report is reviewed and edited based on stakeholder consultations. Timelines are summarized below.

Activity	Start Date	Completion date
Identify data needs in line with the national strategic plan requirements and these reporting guidelines.	December 2009	January 2012
Develop a plan for data collection, analysis and report writing	September 2011	January 2012
Secure required funding for the entire process of collecting, analyzing and reporting the data.	August 2010	January 2012
Collect and collate and analyses data in coordination with partner organizations	January 2012	March 2012
Draft the Country Progress Report narrative	February 2012	March 2012
Allow stakeholders, including government agencies and civil society, to comment on the draft report.	March 23, 2012	March 27, 2012
Validate data against the narrative and enter it into the UNGASS reporting website	March 23, 2012	March 30, 2012
Submit (i) the narrative report and (ii) the indicator data to UNAIDS Geneva before 31 March		March 31,2012

ANNEX 2: National Commitment and Policy Instrument Indicator Trend Analysis 2003 – 2011

NCPI KEY INDICATORS	PERIOD				
	2003	2005	2007	2009	2011
SECTION A					
STRATEGIC PLAN					
Country has developed a national multi-sectoral strategy/action framework to combat HIV/AIDS	-	Yes	Yes	Yes	Yes
Country has integrated HIV/AIDS into its general development plans	-	Yes	Yes	Yes	Yes
Country has evaluated the impact of HIV and AIDS on its socio economic development for planning purposes	-	Yes	Yes	No	No
Country has a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services, military, peacekeepers and police	-	Yes	Yes	Yes	Yes
Strategy planning efforts in the HIV and AIDS programmes overall rating	7	8	8	9	8
POLITICAL SUPPORT					
The head of the government and/or other high officials speak publicly and favourably about AIDS efforts at least twice a year	-	Yes	Yes	Yes	Yes
Country has a national multi-sectoral HIV and AIDS management/coordination body recognized in law? (National AIDS Council or Commission)	-	Yes	Yes	Yes	Yes
Country has a national HIV and AIDS body that promotes interaction between government, people living with HIV, the private sector and civil society for implementing HIV and AIDS strategies/programmes	-	Yes	Yes	Yes	Yes

Country has a national HIV and AIDS body that is supporting coordination of HIV-related service delivery by civil-society organizations	-	Yes	Yes	Yes	Yes
Political support for the HIV/AIDS programme overall rating	-	7	8	7	7

NCPI KEY INDICATORS	PERIOD				
	2003	2005	2007	2009	2011
PREVENTION					
Country has a policy or strategy that promotes information, education and communication (IEC) on HIV and AIDS to the general population	-	Yes	Yes	Yes	Yes
Country has a policy or strategy promoting HIV and AIDS related reproductive and sexual health education for young people (age appropriate)	-	Yes	Yes	Yes	Yes
Country has a policy or strategy to promote and other preventive health interventions for most-at-risk populations (out of school youth added in 2011)	-	Yes	Yes	Yes	Yes
Country has a policy or strategy to expand access, including among most-at-risk populations, to essential preventative commodities.	-	Yes	Yes	Yes	Yes
Policy efforts in support of prevention overall rating	4	6	7	6	7
Prevention activities have been implemented during the period in support of the HIV-prevention policy/strategy	Yes	Yes	Yes	Yes	Yes
Efforts in the implementation of HIV prevention programmes overall rating	6	7	8	9	8
TREATMENT, CARE AND SUPPORT					
Activities have been implemented under the care and treatment of HIV and AIDS programmes	Yes	Yes	Yes	Yes	Yes
Efforts in care and treatment of the HIV/AIDS programme overall rating	6	8	9	9	6
Country has a policy or strategy to address the additional HIV and AIDS-related needs of orphans and other vulnerable children (OVC)	-	Yes	Yes	Yes	Yes

Efforts to meet the needs of orphans and other vulnerable children overall rating	6	7	8	7	5
NCPI KEY INDICATORS	**PERIOD**				
	2003	**2005**	**2007**	**2009**	**2011**
MONITORING & EVALUATION					
Country has one national Monitoring and Evaluation plan	-	IP	Yes	Yes	Yes
There is a budget for the Monitoring and Evaluation plan	-	Yes	Yes	Yes	Yes
There is a Monitoring and Evaluation functional Unit or Department	-	Yes	Yes	Yes	Yes
There is a committee or working group that meets regularly coordinating Monitoring and Evaluation activities	-	IP	Yes	Yes	Yes
Individual agency programmes have been reviewed to harmonize Monitoring and Evaluation indicators with those of your country	-	Yes	Yes	Yes	Yes
Degree (Low to High) to which UN, bi-laterals, other institutions are sharing M&E results 2005-7/Mechanism in place to ensure all key players submit M&E data/reports to M&E unit for inclusion in the national M&E system	-	6/10	4 /5	Yes	Yes
The Monitoring and Evaluation Unit manages a central national database	-	Yes	Yes	Yes	Yes
There is a functional Health Information System	-	Yes	No	Yes	Yes

Country publishes at least once a year an evaluation report on HIV and AIDS, including HIV surveillance reports	-	Yes	Yes	Yes	Yes
Extent to which strategic information is used in planning and implementation?	-	8/10	4/5	4/5	-
In the last year, training in Monitoring and Evaluation was conducted	-	Yes	Yes	Yes	Yes
Monitoring and evaluation efforts of the HIV and AIDS programme overall rating.	6	7	9	9	8
HUMAN RIGHTS – *first year for this section under A*					
Country have a general (i.e. not specific to HIV-related discrimination) law on non-discrimination	-	-	-	-	Yes
Country have laws, regulation or policies that present obstacles to effective HIV prevention, treatment care and support for key populations and vulnerable groups	-	-	-	-	Yes

NCPI KEY INDICATORS	PERIOD				
	2003	2005	2007	2009	2011
SECTION B					
HUMAN RIGHTS					
Country has laws and regulations *(policy)* that protect people living with HIV and AIDS against discrimination (the word policy was added 2011)	-	Yes	No	No	Yes
Country has non-discrimination laws or regulations *(policy)* which specify protections for certain groups of people identified as being especially vulnerable to HIV and AIDS discrimination (the word policy was added 2011)	-	No	Yes	No	Yes
Country has a general (i.e. not specific to HIV –related discrimination) law on non-discrimination.	-	-	-	-	Yes
Country has laws and regulations that present obstacles to effective HIV prevention and care for most-at-risk populations	-	No	Yes	Yes	Yes
The promotion and protection of human rights is explicitly mentioned in an HIV and AIDS policy/strategy	-	Yes	Yes	Yes	Yes
The Government has, through political and financial support, involved vulnerable populations in governmental HIV-policy design and programme implementation	-	Yes	Yes	Yes	Yes
Country has a policy to ensure equal access, between men and women, to prevention and care	-	Yes	Yes	Yes	No
Country has a policy to ensure equal access to prevention and care for most-at-risk populations	-	Yes	Yes	Yes	No
Country has a policy prohibiting HIV screening for general employment purposes (appointment, promotion, training, benefits)	-	Yes	Yes	Yes	Yes

Country has a policy to ensure that HIV and AIDS research protocols involving human subjects are reviewed and approved by a national/local ethical review committee	-	Yes	Yes	Yes	Yes
Members of the judiciary have been trained/sensitized to HIV and AIDS and human rights issues that may come up in the context of their work	-	No	Yes	Yes	Yes
Legal support services are available in the country	-	Yes	Yes	Yes	Yes
NCPI KEY INDICATORS	**PERIOD**				
	2003	2005	**2007**	2009	**2011**
There are programmes designed to change societal attitudes of discrimination and stigmatization associated with HIV and AIDS to understanding and acceptance	-	Yes	Yes	Yes	Yes
Policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS overall rating	-	5	6	6	5
Effort to enforce the existing policies, laws and regulations overall rating	-	3	4	5	5
CIVIL SOCIETY PARTICIPATION/ INVOLVEMENT					
Extent to which civil society has made a significant contribution to strengthening the political commitment of top leaders and national policy formulation	-	8/10	2 /5	3/5	3/5
Extent to which civil society representatives have been involved in the planning and budgeting process for the National Strategic Plan on HIV and AIDS or for the current activity plan (attending planning meetings and reviewing drafts)	-	7/10	2/5	3/5	3/5
Extent to which the complimentary services provided by civil society to areas of prevention and care are included in both the National Strategic (i) plans, (ii) reports and (iii) budget.	-	7/10	3/5	(i) 4/5 (ii) 3/5	(i) 4/5 (ii) 4/5

				(iii) 3/5	(iii) 3/5
Country has conducted a National Periodic review of the Strategic Plan with the participation of civil society (2003 – 2005) Extent to which civil society is included in M&E of HIV response? (i) Developing M&E plan, (ii) MERG participation, (iii) local level use/data decision-making	-	Yes	Yes	(i) 3/5	(i) 4/5
				(ii) 3/5	(ii) 3/5
				(iii) 3/5	(iii) 3/5
Civil Society sector representation in HIV efforts inclusive of diverse organizations				4/5	4/5
Extent to which civil society is able to access adequate (i) financial support (ii) technical support to implement HIV activities	-	-	-	(i) 3/5	(i) 3/5
				(i) 3/5	(ii) 2/5
Efforts to increase civil-society participation overall rating	5	8	8	7	8

NCPI KEY INDICATORS	PERIOD				
	2003	2005	2007	2009	2011
PREVENTION					
Prevention activities have been implemented in support of the HIV-prevention policy/strategy	Yes	Yes	Yes	Yes	Yes
Efforts in the implementation of HIV prevention programmes overall rating	6	7	-	8	6
TREATMENT, CARE AND SUPPORT					
Activities have been implemented under the care and treatment of HIV and AIDS programmes	Yes	Yes	Yes	Yes	Yes
Efforts in care and treatment of the HIV/AIDS programme overall rating	6	9	8	8	7
Country has a policy or strategy to address the additional HIV and AIDS-related needs of orphans and other vulnerable children (OVC)	-	Yes	Yes	Yes	Yes
Efforts to meet the needs of orphans and other vulnerable children overall rating	5	8	8	5	4
POLITICAL SUPPORT AND LEADERSHIP					
Has the country, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in government HIV policy design and programme implementation	-	-	-	-	Yes
- represents questions that were not reflected on the tool					