

## Jamaica Report NCPI

### NCPI Header

#### COUNTRY

**Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any:**

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**Describe the process used for NCPI data gathering and validation:**

A collaborative inquiry was used to identify stakeholders and to select the most appropriate sections of the tool for them to complete. A management team coordinated a team of trained interviewers comprising civil society and government to conduct interviews. The data was collated as per component area for part A and B of the tool. For areas that required a rating an average was recorded on a master questionnaire. For all other responses, they were reviewed for the similarity and accuracy of responses. The time frame in which the activity was conducted was also examined to ensure that it was within the time frame of the evaluation. The validation of data was conducted throughout the process using information from the desk review to gauge qualitative information from stakeholders and information that did not fall within the timeframe of the index (Jan 2010 – Dec 2011) was removed. Areas that remain in question that could not be sourced or otherwise validated were brought to the final stakeholders' validation session for further discussion.

**Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:**

Disagreements were resolved by reviewing the literature to identify what had been documented in national programme or civil society reports. Other areas of disagreement were discussed by the management team or brought to the stakeholders for consensus.

**Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):**

The changing nature of the tool makes a trend analysis difficult as section change as priority area change and country programmes develop. Though section A and B shares a component called political support and leadership they have little in common on which to compare.

**NCPI - PART A [to be administered to government officials]**

| Organization                        | Names/Positions   | A.I | A.II | A.III | A.IV | A.V | A.VI |
|-------------------------------------|---|-----|------|-------|------|-----|------|
| NHP                                 | Dr. Nichola Skyers - Acting Director, NHP                             | Yes | Yes  | Yes   | Yes  | Yes | Yes  |
| MoHEWL                              | Ms. Monica Dystent - Senior Social Worker                             | Yes | Yes  | No    | No   | No  | No   |
| TPDCo                               | Ms. Rachel Morrison - HIV Programme Officer                           | No  | Yes  | No    | Yes  | Yes | No   |
| Department of Correctional Services | Dr. Donna Royer-Powel - Dir. of Medical Correction Services           | Yes | No   | Yes   | Yes  | No  | Yes  |
| SRHA                                | Dr. Vitillus Holder - Reg. HIV Coordinator - Southern                 | Yes | No   | No    | Yes  | Yes | Yes  |
| NERHA                               | Dr. Jeremy Knight - Reg. HIV Coordinator - North East                 | Yes | No   | No    | Yes  | Yes | Yes  |
| NHP                                 | Dr. Clive Anderson - Director TCS                                     | No  | No   | No    | No   | Yes | No   |
| NHP                                 | Dr. Sharlene Jarrett - Senior Director M&E                            | Yes | No   | No    | No   | No  | Yes  |
| NHP                                 | Ms. Patricia Donald - Gender Equality & HIV Technical Advisor         | No  | No   | Yes   | No   | No  | No   |
| NHP                                 | Mrs. Sannia Sutherland - Actg. Director, Prevention                   | Yes | Yes  | No    | Yes  | Yes | Yes  |
| NHP                                 | Mrs. Saani Fong - Actg. Director, Enabling Environment & Human Rights | Yes | Yes  | Yes   | No   | No  | No   |

|      |  |    |     |    |     |     |     |
|------|--|----|-----|----|-----|-----|-----|
| MLSS | Ms. Peta-gay Pryce - HIV Programme Manager         | No | Yes | No | No  | No  | No  |
| NCDA | Ms. Collette Brown - Executive Director            | No | No  | No | Yes | Yes | No  |
| WRHA | Dr. Simone Spence - Reg. HIV Coordinator - Western | No | No  | No | Yes | Yes | Yes |

NCPI - PART B [to be administered to civil society organizations, bilateral agencies, and UN organizations]

| Organization                         | Names/Positions   | B.I | B.II | B.III | B.IV | B.V |
|--------------------------------------|---|-----|------|-------|------|-----|
| UNAIDS                               | Dr. Somse & Ms. Evra Jean Stevens - Country Coordinator & M&E Adviser           | Yes | Yes  | Yes   | Yes  | Yes |
| CDA                                  | Mrs. Gloria Goffe - Project Coordinator   | Yes | No   | Yes   | Yes  | No  |
| PAHO                                 | Dr. Kam Suan Mung - PAHO/WHO Representative                                     | No  | Yes  | No    | No   | Yes |
| HPP/Futures Group                    | Mrs. Sandra McLeish - Jamaica Technical Advisor                                 | Yes | Yes  | Yes   | No   | No  |
| UNFPA                                | Mr. Marvin Gunter - HIV Specialist  | Yes | Yes  | Yes   | Yes  | Yes |
| Children First Youth Centre          | Ms. Claudette Pious - Executive Director  | Yes | No   | No    | Yes  | No  |
| C Change Project                     | Mrs. Kathy Francis Mc Clure - Chief of Party                                    | Yes | Yes  | Yes   | Yes  | No  |
| World Learning                       | Mrs. Ruth Jankee - Project Director for Jamaica and the Bahamas                 | Yes | Yes  | Yes   | Yes  | Yes |
| JN Plus                              | Ms. Nadine Lawrence & Ms. Donna Palmer - NHDRRS Officer & Programme Coordinator | Yes | Yes  | Yes   | Yes  | Yes |
| NAC                                  | Ms. Tanya Powell - Programme Specialist   | Yes | Yes  | Yes   | Yes  | No  |
| UNESCO                               | Ms. Jenelle Bab - National Programme Officer for HIV/AIDS                       | Yes | Yes  | Yes   | No   | No  |
| USAID                                | Dr. Jennifer Knight-Johnson - Project Management Specialist (Health)            | Yes | Yes  | Yes   | Yes  | No  |
| JASL                                 | Mrs. Kandasi Levermore - Executive Director                                     | Yes | Yes  | Yes   | Yes  | Yes |
| Red Cross                            | Ms. Lois Hue - Deputy Director General  | Yes | No   | No    | Yes  | Yes |
| UNICEF                               | Ms. Novia Condell-Gibson - Children & HIV/AIDS Specialist                       | No  | No   | Yes   | Yes  | Yes |
| Children of Faith                    | Mrs. Gloria Meredith - Executive Director                                       | Yes | No   | Yes   | Yes  | Yes |
| Jamaica Council of Churches          | Mr. Garth Minot - Anglican Tutor UTCWI & Chaplin UWI                            | No  | No   | Yes   | No   | No  |
| Hope Worldwide                       | Ms. Karen Daye - Programme Coordinator  | Yes | No   | Yes   | Yes  | No  |
| Jamaica Business Council on HIV/AIDS | Ms. Karlene Temple Anderson - Workplace Technical Officer                       | Yes | Yes  | Yes   | No   | No  |
| Clinton Health Access Initiative     | Ms. Ingrid Thame - Country Director   | No  | No   | No    | Yes  | Yes |
| Jamaica Employers Federation         | Mrs. Brenda Cuthbert - CEO  | No  | Yes  | No    | No   | No  |

## A - I. STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV?

**(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2):**

Yes

**IF YES, what was the period covered:**

2007 - 2012

**IF YES, briefly describe key developments/modifications between the current national strategy and the prior one.**

**IF NO or NOT APPLICABLE, briefly explain why.:**

The present strategy focuses on scaling up prevention activities for MARPs with emphasis on OSY, MSM and SW. It includes addressing the positive prevention needs of PLHIV and stressing the greater involvement of PLHIV in the national response. Capacitating clinicians in the treatment, care and support management of HIV clients in the regional health authorities as well as increasing accessing to treatment. The integration of new categories of staff such as PLHIV liaison officers as a part of the prevention team was an instrumental part of the strategy. The 2007-2012 strategic plan clearly articulated the major priority areas that currently make-up the NHP i.e. M&E, TCS, Prevention and EEHR, this was not clearly articulated in previous

strategies.

1.1 Which government ministries or agencies

**Name of government ministries or agencies [write in]:**

Ministry of Health

1.2. Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

SECTORS

**Included in Strategy**    **Earmarked Budget**

|     |     |
|-----|-----|
| Yes | Yes |
| Yes | Yes |
| Yes | Yes |
| Yes | Yes |
| Yes | Yes |
| Yes | Yes |
| Yes | Yes |

**Other [write in]:**

Correctional Services and Tourism

**IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?:**

-

1.3. Does the multisectoral strategy address the following key populations, settings and cross-cutting issues?

**Men who have sex with men:**

Yes

**Migrants/mobile populations:**

Yes

**Orphans and other vulnerable children:**

Yes

**People with disabilities:**

Yes

**People who inject drugs:**

No

**Sex workers:**

Yes

**Transgendered people:**

No

**Women and girls:**

Yes

**Young women/young men:**

Yes

**Other specific vulnerable subpopulations:**

Yes

**Prisons:**

Yes

**Schools:**

Yes

**Workplace:**

Yes

**Addressing stigma and discrimination:**

Yes

**Gender empowerment and/or gender equality:**

Yes

**HIV and poverty:**

Yes

**Human rights protection:**

Yes

**Involvement of people living with HIV:**

Yes

**IF NO, explain how key populations were identified?:**

**1.4. What are the identified key populations and vulnerable groups for HIV programmes in the country [write in]?:**

Young men and women, MSM, SW, women and girls, OVC, unattached youth (OSY), disabled persons, homeless person, prisoners, migrants and drug users are the key populations identified by the country. Persons in low-income areas and high prevalence communities are also considered as being vulnerable.

**1.5. Does the multisectoral strategy include an operational plan?:** Yes

1.6. Does the multisectoral strategy or operational plan include

**a) Formal programme goals?:**

Yes

**b) Clear targets or milestones?:**

Yes

**c) Detailed costs for each programmatic area?:**

Yes

**d) An indication of funding sources to support programme implementation?:**

Yes

**e) A monitoring and evaluation framework?:**

Yes

1.7

**1.7. Has the country ensured “full involvement and participation” of civil society in the development of the multisectoral strategy?:**

Active involvement

**IF ACTIVE INVOLVEMENT, briefly explain how this was organised:**

The NHP has sought to include and engage a broad spectrum of civil society groups for sensitization sessions, feedback activities related to the development of national plans and strategies. CS actors were instrumental in consultations with the NHP to develop specific content for the NSP, as well as consultation workshops with target groups, to gain consensus and feedback on initiatives as well as to share information with stakeholders.

**1.8. Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?:**

Yes

1.9

**1.9. Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?:**

Yes, all partners

**2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment / UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?:**

Yes

2.1. IF YES, is support for HIV integrated in the following specific development plans?

**Common Country Assessment/UN Development Assistance Framework:**

Yes

**National Development Plan:**

Yes

**Poverty Reduction Strategy:**

Yes

**Sector-wide approach:**

Yes

**Other [write in]:**

-

2.2. IF YES, are the following specific HIV-related areas included in one or more of the development plans?

**HIV impact alleviation:**

Yes

**Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support:**

Yes

**Reduction of income inequalities as they relate to HIV prevention/treatment, care and/or support:**

Yes

**Reduction of stigma and discrimination:**

Yes

**Treatment, care, and support (including social security or other schemes):**

Yes

**Women's economic empowerment (e.g. access to credit, access to land, training):**

Yes

**Other[write in below]:**

-

**3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?:**

No

**4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?:**

Yes

**5. Has the country followed up on commitments made in the 2011 Political Declaration on HIV/AIDS?:**

Yes

**5.1. Have the national strategy and national HIV budget been revised accordingly?:**

No

**5.2. Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?:**

Estimates of Current and Future Needs

**5.3. Is HIV programme coverage being monitored?:**

Yes

5.3

**(a) IF YES, is coverage monitored by sex (male, female)?:**

Yes

**(b) IF YES, is coverage monitored by population groups?:**

Yes

**IF YES, for which population groups?:**

For the general population, MSM, SW, drug users, OSY, pMTCT clients, inmate, pregnant women and neonate children.

**Briefly explain how this information is used:**

The information is used for strategic planning purposes, to design prevention interventions based on current epidemiology, set priorities and to track programme successes. It is also used to monitor the impact of programme interventions, and as such provides justification for resource allocation and programme reviews that determine whether interventions are scaled up or down.

**(c) Is coverage monitored by geographical area:**

Yes

**IF YES, at which geographical levels (provincial, district, other)?:**

Coverage is monitored by health district, parish and health region, however, the data set is skewed to the public sector as reporting mechanisms are limited for the private sector.

**Briefly explain how this information is used:**

The information enables resource allocation for targeted interventions in high-risk locations that can be specifically structured to the populations needs. Additionally, it is used to set targets in a given location.

**5.4. Has the country developed a plan to strengthen health systems?:**

Yes

**Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications:**

In an effort to strengthen and sustain the national response, plans are afoot to integrate the NHP into the NFPB. This would improve the financial management and programme implementation of the national HIV response. Other systems strengthening activities are the integration of Health Corporation Limited and the National Health Fund for the procurement of drugs and health commodities and HIV treatment sites now contracts psychologist to assist with the psychosocial management of clients. In addition, there is the introduction of new logistical systems, computer systems, national protocols, and electronic databases with on-going training in several programme areas to improve the capacity of staff.

**6. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate strategy planning efforts in the HIV programmes in 2011?:**

8

**Since 2009, what have been key achievements in this area:**

The development of NSP for 2012-2017, which included wide stakeholder input through consultations with the general population, the LGBT community and CS is a key achievement since 2009. So is the completion of the proposal for Global Fund Round 11. Research conducted with MSM and SW and the development of media campaigns that tested well once evaluated should also be recognized. Contracting a time-bound Gender Specialist Consultant who supports gender mainstreaming and PLHIV Liaisons Officers are new positions that supplement the prevention team. Treatment and Care has benefited greatly from improved laboratory capacity by way of the modernization of NPHL. Improved M&E systems, an evaluation of the HIV programme and preparation process to facilitate the integration into NFPB have been significant achievements.

**What challenges remain in this area:**

From a governance perspective, the programme prepared for integration into the NFPB hence the NHP as a separate organization winds down with high levels of uncertainty among staff, which may impact future programme implementation efforts. Hence, sustainability issues are a major concern; job security is uncertain, and staff morale is low. The programme still

struggle with conducting evaluations of prevention initiatives and adherence to treatment remains a challenge. Persistent high prevalence rates among MSM and stigma and discrimination that limit access of MSM to treatment care and support remain areas of concern.

## A - II. POLITICAL SUPPORT AND LEADERSHIP

1. Do the following high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year

**A. Government ministers:**

Yes

**B. Other high officials at sub-national level:**

Yes

1.1

**(For example, promised more resources to rectify identified weaknesses in the HIV response, spoke of HIV as a human rights issue in a major domestic/international forum, and such activities as visiting an HIV clinic, etc.):**

Yes

**Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:**

There have been a number of activities that demonstrate leadership in the Jamaica since 2009. The current Prime Minister openly stated that persons should be selected for Cabinet duties on the basis of their capacity to deliver contradicting pervious views that limited homosexuals from serving in that capacity. She also stated an intention to review the country's buggery law should she be returned as Prime Minister of Jamaica in 2011.

(<http://www.jamaicaobserver.com/elections/news/Portia-promises-to-review-buggery-law>) Also, Declaration of Commitment to Eliminate Stigma, Discrimination and Gender Inequality affecting Jamaica's HIV and AIDS Response (2011). The then Prime Minister and Leader of the Opposition, Hon. Bruce Golding and Mrs Portia Simpson Miller respectively signed this declaration and a draft cabinet submission to amend the Public Health Orders, which would remove discriminatory provisions relating to PLWHA have been drafted and submitted to the relevant authorities.

**2. Does the country have an officially recognized national multisectoral HIV coordination body (i.e., a National HIV Council or equivalent)?:**

Yes

2.1. IF YES, does the national multisectoral HIV coordination body

**Have terms of reference?:**

Yes

**Have active government leadership and participation?:**

Yes

**Have an official chair person?:**

Yes

**IF YES, what is his/her name and position title?:**

Mr. Leopold Nesbeth - Chairman

**Have a defined membership?:**

Yes

**IF YES, how many members?:**

130

**Include civil society representatives?:**

Yes

**IF YES, how many?:**

104

**Include people living with HIV?:**

Yes

**IF YES, how many?:**

26

**Include the private sector?:**

Yes

**Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?:**

Yes

**3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?:**

Yes

**IF YES, briefly describe the main achievements:**

The NAC through the CCM promotes partnerships and monitors grants to civil society groups. They conduct community-based

outreach, facilitate testing and outreach to PLHIV to get grants for income generating activities. They are also involved in prevention initiatives such as condom distribution through the Parish AIDS Associations (PAA). The CCM consistently revises the governance manuals and have completed the eligibility criteria for submission to the Global Fund. This, even though the country has been categorized as upper middle-income (UMI) and thus is eligible for less funding allocations.

**What challenges remain in this area:**

The NAC is challenged by capacity attrition, lack of funding, inability to coordinate due to their HR capacity issues that limited their ability to operate efficiently. The CCM has new representatives and hence are challenged with a lack of continuity and experience in operationalizing their TOR. The PAA depends on volunteerism and hence it is difficult for them to remain functional.

**4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?:**

29.4%

5.

**Capacity-building:**

Yes

**Coordination with other implementing partners:**

Yes

**Information on priority needs:**

Yes

**Procurement and distribution of medications or other supplies:**

Yes

**Technical guidance:**

Yes

**Other [write in below]:**

-

**6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National HIV Control policies?:**

Yes

**6.1. IF YES, were policies and laws amended to be consistent with the National HIV Control policies?:**

Yes

**IF YES, name and describe how the policies / laws were amended:**

Sexual Offences Act was amended. While the offence of rape as defined under the Sexual Offences Act, can only be committed by a man against a woman, the law now recognises grievous sexual assault. This offence can be perpetrated by a man against a man or a woman. The offence can also be committed by a woman against a man or a woman. It should be noted that there is no disparity in penalty for both rape and grievous sexual assault. The new law now recognises both males and females as perpetrators of the crime of incest. The offence of incest has been expanded to include any person who knowingly has sexual intercourse with an uncle, nephew, niece, aunt and grandmother. In relation to HIV, it should be noted that wilful transmission of HIV is not an offence.

**Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:**

Although not complete, work is in progress to amend the Public Health Orders, which would remove what could be regarded as discriminatory provisions relating to PLHIV. Adolescent access to HIV testing and services for persons under 16 years without parental consent is prohibited. The Offences against the Persons Act that makes buggary (by both males and females) illegal and sex work is criminalized. All these occurrences inhibit the promotion of and can hinder access to HIV prevention and treatment services by vulnerable populations. Although there is the Charter of Fundamental Rights and Freedoms it has gaps in addressing issues regarding the health, status and social orientation of persons.

**7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the political support for the HIV programme in 2011?:**

7

**Since 2009, what have been key achievements in this area:**

The HIV programme has benefitted from several efforts since 2009. There are several major government ministries that have HIV policies with active prevention and anti-discrimination programmes. Some of these are the Ministry of Health, Youth, Office of Services Commission, and Ministry of Labour & Social Security. There is an activated Voluntary Compliance Programme through the Ministry of Labour for public and private sector entities regarding HIV policies and non-discriminatory practices in the workplace. The signed Declaration of Commitment by the PM and Opposition leader in 2011 to eliminate S&D and Gender inequality affecting the HIV response is a major political achievement so is the High level leadership commitment to remove discriminatory provisions of the Public Health Act.

**What challenges remain in this area:**

In light of competing economic and other social issues, HIV is not seen as a priority. There are dominant cultural and religious perceptions of HIV and sexuality that impact programmes targeting vulnerable population, and although there have been achievements made in political support, these achievements need to trickle down into policy reform. Additionally, effort to scale up the protection of human rights for MSM and other vulnerable population needs improvement.

## A - III. HUMAN RIGHTS

1.1

**People living with HIV:**

Yes

**Men who have sex with men:**

Yes

**Migrants/mobile populations:**

No

**Orphans and other vulnerable children:**

Yes

**People with disabilities:**

Yes

**People who inject drugs:**

No

**Prison inmates:**

No

**Sex workers:**

No

**Transgendered people:**

No

**Women and girls:**

Yes

**Young women/young men:**

Yes

**Other specific vulnerable subpopulations [write in]:**

-

**1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?:**

Yes

**IF YES to Question 1.1. or 1.2., briefly describe the content of the/laws:**

Section 13(3) of the Charter of Fundamental Rights and Freedoms provides for non-discrimination on the grounds of being male or female, place of origin, social class, religion or political opinion. The revised Civil Service Order (2004) provides for non-discrimination on the grounds of age, gender, national origin, race, colour, religious beliefs, political affiliation, disability and sexual orientation. There are no policies, laws or regulations that specify protection for sex workers. However, there are policies that specify key populations such as MSM and youth (National HIV/AIDS Policy, National Policy for Management of HIV in Schools) and the Sexual Offences Act recognizes that sexual assault (not rape) against men. There is also a National Policy for Gender Equality with an objective of reducing all forms of gendered discrimination and promoting greater gender equality and social justice.

**Briefly explain what mechanisms are in place to ensure these laws are implemented:**

The Charter of Rights of Fundamental Rights and Freedoms provides redress against the state for any breaches of constitutional rights, including discrimination. The Supreme Court addresses allegations of breaches to the Civil Service Staff Orders.

**Briefly comment on the degree to which they are currently implemented:**

The provision in the Charter of Fundamental Rights and Freedoms has not yet been utilized in the domestic courts.

**2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?:**

Yes

IF YES, for which subpopulations?

**People living with HIV:**

Yes

**Men who have sex with men:**

Yes

**Migrants/mobile populations:**

Yes

**Orphans and other vulnerable children:**

No

**People with disabilities:**

No

**People who inject drugs :**

Yes

**Prison inmates:**

Yes

**Sex workers:**

Yes

**Transgendered people:**

No

**Women and girls:**

Yes

**Young women/young men:**

Yes

**Other specific vulnerable subpopulations [write in below]:**

-

**Briefly describe the content of these laws, regulations or policies:**

• Offences Against the Person Act makes the act of buggery illegal • Age of consent for sexual intercourse being 16 limits access to contraceptives and HIV testing. • Education Regulations- that prevent persons with communicable diseases (which includes HIV) from attending school • Public Health Regulations- that prevent persons with communicable disease (which includes HIV) from working in food industry, hotel establishments, using public swimming pools • Laws against sex work and illegal drug use

**Briefly comment on how they pose barriers:**

Offences Against the Persons Act, Education Regulations and Public Health Regulations are discriminatory, while the age of consent for sexual intercourse and laws against sex work and illegal drug use prohibit or limit access of vulnerable populations to treatment care and support services.

## A - IV. PREVENTION

**1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population?:**

Yes

IF YES, what key messages are explicitly promoted?

**Abstain from injecting drugs:**

No

**Avoid commercial sex:**

No

**Avoid inter-generational sex:**

No

**Be faithful:**

Yes

**Be sexually abstinent:**

Yes

**Delay sexual debut:**

Yes

**Engage in safe(r) sex:**

Yes

**Fight against violence against women:**

Yes

**Greater acceptance and involvement of people living with HIV:**

Yes

**Greater involvement of men in reproductive health programmes:**

Yes

**Know your HIV status:**

Yes

**Males to get circumcised under medical supervision:**

No

**Prevent mother-to-child transmission of HIV:**

Yes

**Promote greater equality between men and women:**

Yes

**Reduce the number of sexual partners:**

Yes

**Use clean needles and syringes:**

No

**Use condoms consistently:**

Yes

**Other [write in below]:**

Substance use Tolerance for sexual orientation Accurate condom use Concurrency Transactional sex

**1.2. In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?:**

Yes

**2. Does the country have a policy or strategy to promote life-skills based HIV education for young people?:**

Yes

2.1. Is HIV education part of the curriculum in

**Primary schools?:**

Yes

**Secondary schools?:**

Yes

**Teacher training?:**

Yes

**2.2. Does the strategy include age-appropriate, gender-sensitive sexual and reproductive health elements?:**

Yes

**2.3. Does the country have an HIV education strategy for out-of-school young people?:**

Yes

**3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for key or other vulnerable sub-populations?:**

Yes

**Briefly describe the content of this policy or strategy:**

The NSP 2007 – 2012 speaks to committing more resources to programmes for MARPs in terms of information, testing and increased peer-driven prevention programmes. Specific activities include empowerment session targeting MSM, SW and OSY. These include VCT and STI testing, condom demonstration, negotiation and free distribution, income generating, remedial literacy, lubricant distribution, personal hygiene, positive prevention, financial management, parenting and SRH, developing IEC specific to MARPs groups and media advertising, encouraging risk reduction conversations.

**3.1. IF YES, which populations and what elements of HIV prevention does the policy/strategy address?**

| IDU | MSM | Sex workers | Customers of Sex Workers | Prison inmates | Other populations  |
|-----|-----|-------------|--------------------------|----------------|--|
| No  | Yes | Yes         | Yes                      | Yes            | Homeless drug addicts & males and females in high prevalence communities |
| No  | No  | No          | No                       | No             | -  |
| No  | Yes | Yes         | Yes                      | Yes            | Homeless drug addicts & males and females in high prevalence communities |
| No  | No  | No          | No                       | No             | -  |
| No  | Yes | Yes         | Yes                      | Yes            | Homeless drug addicts & males and females in high prevalence communities |
| No  | Yes | Yes         | Yes                      | Yes            | Homeless drug addicts & males and females in high prevalence communities |
| No  | Yes | Yes         | Yes                      | Yes            | Homeless drug addicts & males and females in high prevalence communities |
| No  | Yes | Yes         | No                       | No             | Homeless drug addicts & males and females in high prevalence communities |

**3.2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate policy efforts in support of HIV prevention in 2011?:**

7

**Since 2009, what have been key achievements in this area:**

The institutionalization for VCT for new prisoners, Political commitment to reduce gender inequality and promote human rights, the completion of NSP for adolescent conducted by the MoH and preadolescent and HFLE implementation in 92% of schools are all strident policy efforts completed in 2011. The perceived reduction in stigma towards MSM, increased uptake of prevention services and referrals to other social services such as Jamaica Foundation of Livelong Learning and Register General Department and the maintained decrease in HIV prevalence, in the sex worker population are also admirable achievements.

**What challenges remain in this area:**

The legal frameworks that limit access and impede implementation of activities with key affected populations (MSM, SW, inmates) remains a challenge. There is only limited access to sub-populations of the MARPs and prevalence rates for MSM remain high. Insufficient government funding to support programme implementation, heavy support on donor funds and reduced access to health care due to real of received discrimination remaining on-going challenges.

**4. Has the country identified specific needs for HIV prevention programmes?:**

Yes

**IF YES, how were these specific needs determined?:**

Several mechanisms are used to determine the HIV prevention needs. International commitment and declarations are consulted and adhered to, and international and local research findings are used to assist in the development of interventions strategies for key population i.e. National KAPB, second generation MSM and SW surveys, surveillance data, epidemiology data, focus group discussion analysis. Information from the monitoring and evaluation of existing programmes and

interventions is consulted to identify programme needs. Stakeholder consultations at all levels and with all partners including NGO, FBO, clients of services, civil society, other private sector entities, as well as demand. The major focus is to highlight evidence based programming.

4.1. To what extent has HIV prevention been implemented?

**Blood safety:**

Strongly Agree

**Condom promotion:**

Strongly Agree

**Harm reduction for people who inject drugs:**

N/A

**HIV prevention for out-of-school young people:**

Agree

**HIV prevention in the workplace:**

Agree

**HIV testing and counseling:**

Strongly Agree

**IEC on risk reduction:**

Strongly Agree

**IEC on stigma and discrimination reduction:**

Agree

**Prevention of mother-to-child transmission of HIV:**

Strongly Agree

**Prevention for people living with HIV:**

Agree

**Reproductive health services including sexually transmitted infections prevention and treatment:**

Agree

**Risk reduction for intimate partners of key populations:**

Agree

**Risk reduction for men who have sex with men:**

Agree

**Risk reduction for sex workers:**

Strongly Agree

**School-based HIV education for young people:**

Agree

**Universal precautions in health care settings:**

Strongly Agree

**Other[write in]:**

Risk reduction in the general population - strongly agree

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in implementation of HIV prevention programmes in 2011?:

8

## A - V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?:

Yes

**If YES, Briefly identify the elements and what has been prioritized:**

The provision of screening and diagnostic services, psychosocial support, adherence, positive preventing programmes, testing and counselling, specialized treatment sites, ARVs, constant and consistent client follow-up and monitoring. Sexual and reproductive health has been prioritized with the provision of standardized ART protocols, income-generating grants and capacity building workshops.

**Briefly identify how HIV treatment, care and support services are being scaled-up?:**

Infrastructural improvements of the NPHL and treatments sites are on-going, and the hiring of regional psychologists and PLHIV liaison officers has assisted with care services. There has been an increase in number of treatment sites providing HIV testing and treatment services. MARPs have been targeted using A&E services. Scaling up ART and retraining clinician are occurring. Programmes targeting PLHIV lost to follow-up are implemented along with HIV drug resistant testing. Improved testing opportunities and partnerships with the private sector in terms of trained care providers and dispensing medication through Drug Serv pharmacies (at private sector pharmacies) are occurring.

1.1. To what extent have the following HIV treatment, care and support services been implemented?

**Antiretroviral therapy:**

Agree

**ART for TB patients:**

Agree

**Cotrimoxazole prophylaxis in people living with HIV:**

Agree

**Early infant diagnosis:**

Strongly Agree

**HIV care and support in the workplace (including alternative working arrangements):**

Disagree

**HIV testing and counselling for people with TB:**

Agree

**HIV treatment services in the workplace or treatment referral systems through the workplace:**

Disagree

**Nutritional care:**

Disagree

**Paediatric AIDS treatment:**

Strongly Agree

**Post-delivery ART provision to women:**

Strongly Agree

**Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault):**

Agree

**Post-exposure prophylaxis for occupational exposures to HIV:**

Strongly Agree

**Psychosocial support for people living with HIV and their families:**

Agree

**Sexually transmitted infection management:**

Agree

**TB infection control in HIV treatment and care facilities:**

Disagree

**TB preventive therapy for people living with HIV:**

Disagree

**TB screening for people living with HIV:**

Disagree

**Treatment of common HIV-related infections:**

Strongly Agree

**Other [write in]:**

PMTCT - strongly agree Routine follow-up - agree Testing PLHIV - agree CD4/viral load - agree

**2. Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?:**

Yes

**Please clarify which social and economic support is provided:**

Social support is provided through counselling and psychological services such as support groups, referrals to various agencies for the following: income generating opportunities, food support, removal of user fees, free ARV medication provision and through the Programme Advancement through Health and Education (PATH) The PATH programme provides some economic support.

**3. Does the country have a policy or strategy for developing/using generic medications or parallel importing of medications for HIV?:**

Yes

**4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy medications, condoms, and substitution medications?:**

No

**5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care, and support programmes in 2011?:**

7

**Since 2009, what have been key achievements in this area:**

Since 2009, there has been improved laboratory capacity i.e. diagnosis, rapid testing, CD4 viral load with the expansion of laboratories in rural areas. Portable CD4 machines have been introduced in treatment sites hence, reducing the turnaround time for results. Expanded lists of ARVs that include third line drugs are now available. Revisions/updates to the pMTCT manual and treatment guidelines have been completed. The preceptorship ST/HIV training has also been expanded and vaccine and ARV research as well as research to improve HIV drug resistance testing has been conducted. Epidemiology data have indicated an increase in the number of PLHIV accessing services, in government facilities. Expanded testing of HIV exposed babies has commenced. Access to testing and medication has continued to improve through enhanced engagement of the private sector ARV through Drug Serv pharmacies.

**What challenges remain in this area:**

The ability to reach MARPs to conduct testing, ARV adherence and to maintain patients on care remains challenges. Stigma and discrimination towards MARPs in health care setting along with the limited involvement of private practitioners in the management of PLHIV are areas in need of strengthening. Improve procurement and supply management is a necessity along with improve data gathering, sustainability specific to the maintenance of funding of ARV programme and all other programme areas. The low uptake of peer support group is also proving to be a challenge.

**6. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?:**

No

**7. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011?:**

5

**Since 2009, what have been key achievements in this area:**

Some TCS (OVC) have universal access to HIV services. Interventions are in places of safety and juvenile correctional facilities.

**What challenges remain in this area:**

There is low knowledge about TCS (OVC) among stakeholders hence the programme and its accomplishments needs to be more visible. There is inadequate research data and M&E to guide policy strategies. Again the laws and policies that restrict access to SRH services for minors impact OVC.

## **A - VI. MONITORING AND EVALUATION**

**1. Does the country have one national Monitoring and Evaluation (M&E) plan for HIV?:**

Yes

**Briefly describe any challenges in development or implementation:**

There are difficulties in getting the private sector involved in the development and review of the treatment component of the M&E plan. Limited funding negatively impact the ability to provide dedicated M&E staff outside of the NHP, effective computerized systems including software to enable and facilitate data input and to capacitate field staff in its use. With no dedicated M&E staff at the regional and parish level, competing agendas results in shifting programme priorities and delays in receipt of reports.

**1.1 IF YES, years covered:**

2007 - 2012

**1.2 IF YES, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?:**

Yes, some partners

**Briefly describe what the issues are:**

To standardize all the necessary and competing indicators into one reporting form that is not overwhelming for staff to complete is in itself challenging. Additionally, with new and emerging indicators constantly being identified, it is an on-going task to develop and or incorporate them into existing data collection systems and train/orient staff regarding these changes, particular in a short time frame.

2. Does the national Monitoring and Evaluation plan include?

**A data collection strategy:**

Yes

**Behavioural surveys:**

Yes

**Evaluation / research studies:**

Yes

**HIV Drug resistance surveillance:**

No

**HIV surveillance:**

Yes

**Routine programme monitoring:**

Yes

**A data analysis strategy:**

No

**A data dissemination and use strategy:**

Yes

**A well-defined standardised set of indicators that includes sex and age disaggregation (where appropriate):**

Yes

**Guidelines on tools for data collection:**

Yes

**3. Is there a budget for implementation of the M&E plan?:**

Yes

**3.1. IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities? :**

7%

**4. Is there a functional national M&E Unit?:**

Yes

**Briefly describe any obstacles:**

The M&E unit supports the NHP, regional and parish teams as well as NGOs, CS and the (23) treatment sites and with no dedicated M&E staff existing outside of the NHP competing agendas and high work loads result in delayed submission of report particular at the sub regional level.

4.1. Where is the national M&E Unit based?

**In the Ministry of Health?:**

Yes

**In the National HIV Commission (or equivalent)?:**

Yes

**Elsewhere [write in]?:**

-

Permanent Staff [Add as many as needed]

**POSITION [write in position titles in spaces below] Fulltime Part time Since when?**

| POSITION [write in position titles in spaces below] | Fulltime | Part time | Since when? |
|---|----------|-----------|-------------|
| Bio-statistician                                    | fulltime | -         | 2004        |
| Director (resigned)                                 | fulltime | -         | 2004        |
| Database officer                                    | fulltime | -         | 2004        |
| Data entry clerk (2)                                | fulltime | -         | 2004        |
| HIV/STI Information Officer                         | fulltime | -         | 2011        |
| M&E Officer   | fulltime | -         | 2007        |
| Research Officer (resigned)                         | fulltime | -         | 2010        |
| Research Officer (new)                              | fulltime | -         | 2011        |
| Senior Director                                     | fulltime | -         | 2011        |
| Director (new)                                      | fulltime | -         | 2011        |
| Surveillance Officer                                | fulltime | -         | 2004        |

Temporary Staff [Add as many as needed]

**POSITION [write in position titles in spaces below] Fulltime Part time Since when?**

| POSITION [write in position titles in spaces below] | Fulltime | Part time | Since when? |
|---|----------|-----------|-------------|
| Data Entry Clerk                                    | fulltime | -         | 2011        |

**4.3. Are there mechanisms in place to ensure that all key partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?:**

Yes

**Briefly describe the data-sharing mechanisms:**

Key partners submit standardized monthly reports to the M&E unit. These partners have been trained in the use of the various forms and the operational manual, which provides guidance on the reporting requirements of the programme. There are also electronic databases at treatment sites that provide additional information for sharing.

**What are the major challenges in this area:**

Staffing for data entry, the completeness and timeliness of reports remain a challenge. However, data for some indicators are difficult to collect. An additional challenge is collecting data on activities that although conducted where not funded by the NHP.

**5. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?:**

Yes

**6. Is there a central national database with HIV- related data?:**

Yes

**IF YES, briefly describe the national database and who manages it.:**

Managed by the NHP the national database covers information from stakeholders of the NHP. It includes:  Regional Quarterly Report and progress report from all health centres (pMTCT, BCC)  Contact Investigation Monthly Summary Statistics Form  Laboratory Rapid Test database summary reports for all hospitals  Line Ministries and Internal programme reports  Stakeholder and sub-recipient reports, including PAA  Special Investigation Form for Congenital Syphilis, ON and Paediatric HIV  Monthly STI Summary Report

**6.1. IF YES, does it include information about the content, key populations and geographical coverage of HIV services, as well as their implementing organizations?:**

Yes, but only some of the above

**IF YES, but only some of the above, which aspects does it include?:**

Regional Quarterly Report and progress report from all health centres (pMTCT, BCC)  Contact Investigators Monthly Summary Statistics Form and other internal reports  Laboratory Rapid Test database summary reports for all hospitals  Line Ministries reports  Stakeholder and sub-recipient reports, including PAA  Special Investigation Form for Congenital Syphilis, ON and Paediatric HIV. It is limited in capturing the complete gamut of activities from civil society groups and the private sector stakeholders as well as providing geographic coverage and to some extent coverage of key populations.

6.2. Is there a functional Health Information System?

**At national level:**

No  
**At subnational level:**  
No  
**IF YES, at what level(s)?:**  
-

**7. Does the country publish an M&E report on HIV , including HIV surveillance data at least once a year?:**

Yes

8. How are M&E data used?

**For programme improvement?:**

Yes

**In developing / revising the national HIV response?:**

Yes

**For resource allocation?:**

Yes

**Other [write in]:**

-

**Briefly provide specific examples of how M&E data are used, and the main challenges, if any:**

M&E data have been used to assist with the estimates of relatively accurate national HIV statistics to guide resource allocations, identify issues and key populations and inform interventions. It has established baselines that guide evaluations of effectiveness in the programme and determined prevalence rates particularly in key populations. The data are, however, underutilized as the system is now able to provide data in several programme and sub-programme areas that have not yet made its way to informing interventions due to a lack of on-going and consistent sharing of data. The availability of the data is delayed due to the late submission of reports and paper based systems.

9. In the last year, was training in M&E conducted

**At national level?:**

Yes

**IF YES, what was the number trained:**

241

**At subnational level?:**

Yes

**IF YES, what was the number trained:**

301

**At service delivery level including civil society?:**

Yes

**IF YES, how many?:**

101

**9.1. Were other M&E capacity-building activities conducted` other than training?:**

Yes

**IF YES, describe what types of activities:**

A review of the surveillance data in preparation for Spectrum and Estimates and Prevention Package(EPP) was completed as well as on-going dissemination of guidelines for databases at data collection sites. A new screening tool was developed for the clinics, and hardware and software to improve reporting was upgraded.

**10. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the HIV-related monitoring and evaluation (M&E) in 2011?:**

8

**Since 2009, what have been key achievements in this area:**

The Country Response Information System (CRIS) has been customized for Jamaica and rolled out to the stakeholders and the M&E operational plan has been disseminated to all stakeholders. MSM and SW surveys and an evaluation of the HIV workplace policy programme have been completed. There has been a thrust to increase awareness of the importance of M&E and to make the M&E process more people-friendly. In such, the electronic databases have undergone strengthening for improved implementation with regular training on sensitization to improve the quality of data collection and evaluations.

**What challenges remain in this area:**

Human resources constraints continue to challenge the unit. A lack of dedicated M&E persons both regional and through stakeholder groups limit the quality, timeliness and thoroughness of reporting. Some stakeholders have limited computer literacy and access, and hence training and funding become major issues to support a functional system. The lack of a dissemination/communication strategy for M&E reduces valuable information from maximally impacting programme implementation.

## **B - I. CIVIL SOCIETY INVOLVEMENT**

**1. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?:**

3

**Comments and examples:**

Civil society's contribution has been noted in the development of the Charter of Fundamental Rights and Freedoms and the universal access consultations that fed into political declarations at both national and international high-level meetings. Their contribution to the creation of the old and new drafts of the NSP was facilitated through various stakeholders' consultations that facilitated both the development of content as well as feedback session. However, there is a concern that civil society is too dependent on government support to advocate effectively and rally for the realization of commitments made at the political level. Civil society is not the driver of the HIV response; they are reliant on funding streams.

**2. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?:**

3

**Comments and examples:**

Although there have been attempts at civil society involvement in planning processes for the NSP through their involvement in consultations, meetings and review processes. There are concerns that only groups that are integrally involved in the NHP or specific organizations are invited to planning processes with the same groups being repeatedly invited to participate. It is also felt that civil society does not always accept the opportunity to participate fully or maybe are unable to participate at that level. Their involvement is seen in some sphere as surface level with the quality of their involvement being in question. However, the budgeting process for the NSP, has very limited involvement, if any at all, from civil society. What is required is broader engagement of all CS, engagement that is not limited to the HIV response.

3.

**a. The national HIV strategy?:**

4

**b. The national HIV budget?:**

3

**c. The national HIV reports?:**

4

**Comments and examples:**

The current national strategy is noted as being very general, however, the services provided by CS are included in the strategy particularly those that target MARPs. JASL provides outreach, testing and treatment services to MSM while JN plus' database is used for verification, systematically to identify and report acts of discrimination. Most CS service stakeholders are recipients of Global and USAID funds and hence would be in receipt of funds from the national budget. Consequently, they would have to adhere to reporting guidelines with outlined indicators and targets in order to access funding. The M&E unit within the NHP receives periodic reports of funded CS programme activities that are included in the national HIV report. However, a national reporting system that covers all stakeholders notwithstanding funding sources is needed.

4.

**a. Developing the national M&E plan?:**

4

**b. Participating in the national M&E committee / working group responsible for coordination of M&E activities?**

:

3

**c. Participate in using data for decision-making?:**

3

**Comments and examples:**

The MERG has CS representation, but their participation in the development of the M&E plan varies depending on their capacity. M&E is a technical area that some CS stakeholders are not versed in and limits their participation. Consequently, even though reports on programme activities are submitted to the M&E unit from CS, there is limited feedback of circulated consolidated programme reports to inform decision-making. The challenge is that there is no systematic dissemination of reports and data.

**5. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. organisations and networks of people living with HIV, of sex workers, and faith-based organizations)?:**

4

**Comments and examples:**

Even though there are diverse organizations that are highly represented in the HIV efforts of CS, there is the need to broaden the reach. Some of the more prominently featured organizations are Jamaica AIDS Support for Life, Jamaica Forum for Lesbians, All-Sexuals and Gays, Jamaica Network for Seropositives, the Jamaica Red Cross, Children First, Caribbean Council of Churches, Eve for Life, GIPA, Sex Workers Organization, Caribbean Vulnerable Communities, Women's Bureau and National Council on Drug Abuse.

**6. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society able to access**

**a. Adequate financial support to implement its HIV activities?:**

3

**b. Adequate technical support to implement its HIV activities?:**

2

**Comments and examples:**

Although funding is available through most UN agencies and other development partners, a substantial amount of funding is directed through the NHP with second tier being given to organizations that have a proven track record to manage resources. It is still thought that personal issues between government and CS influence funding decisions and that funding is never adequate to executive a robust CS programme. Funding, however, is more available in specific programme areas such as; MSM & SW interventions but is limited for interventions targeting the disabled, gang youth, drug users, homeless and homeless persons with AIDS. Civil society was split in regards to their views of adequate technical support. Some stated that it was adequate while others indicated limited technical support.

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

**People living with HIV:**

25-50%

**Men who have sex with men:**

>75%

**People who inject drugs:**

25-50%

**Sex workers:**

25-50%

**Transgendered people:**

51-75%

**Testing and Counselling:**

25-50%

**Reduction of Stigma and Discrimination:**

25-50%

**Clinical services (ART/OI)\*:**

<25%

**Home-based care:**

51-75%

**Programmes for OVC\*\*:**

51-75%

8. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts to increase civil society participation in 2011?:

8

**Since 2009, what have been key achievements in this area:**

The involvement of CS in the discussion and review processes for the development of the NSP 2012- 2017 signified the NHP efforts to facilitate increased participation of CS. There has also been marked improvement in CSO engagement and partnership visible through CS presence at high-level consultations. CS provided leadership to the NHP retreat 2011. CS has increased participation in the CCM and the dissemination of research information and participation in planning processes has been more inclusion of CS. In addition to issues regarding policy and legislation, they contributed to the political declarations.

**What challenges remain in this area:**

There is limited alignment to the broad development agenda, insufficient strategic planning and limited leadership within some CS. They will have to improve on professionalism in programme results even though they are challenged with human and organizational capacity. Frequently centered on KSA, CS has limited representation in rural areas. Nonetheless, the NHP has to internalize the volume of CS as legitimate and credible partners and be willing to share resources with them, which has been an area of ongoing discussions. NHP has been described as being territorial and competitive and needs to investigate the effectiveness of disbursing funds to some CSOs as they hold the belief that the funds are wasted. If this proves true, then the NHP needs to provide funds to organizations that are capable of providing services and build the capacity of those CSOs. Concerns exist that the needs of particular target groups such as out of school youth, the disabled and drug users are unmet.

## **B - II. POLITICAL SUPPORT AND LEADERSHIP**

1. Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation?:

Yes

**IF YES, describe some examples of when and how this has happened:**

There have been efforts to involve PLHIV through the process of their participation in the CCM, being sub -recipients of Global Funds and involvement in the NHP annual retreat. The GIPA unit, although spearheaded by the Enabling Environments component of the NHP, is supported by government funds. However, there is room for much improvement in regards to the involvement of other populations, such as LGBTQ, drug users, marginalized youth for e.g. OSY, homeless, homeless PLHIV, youth in gangs and young MSM.

## **B - III. HUMAN RIGHTS**

1.1.

**People living with HIV:**

Yes

**Men who have sex with men:**

Yes

**Migrants/mobile populations:**

No

**Orphans and other vulnerable children:**

Yes

**People with disabilities:**

Yes

**People who inject drugs:**

No

**Prison inmates:**

No

**Sex workers:**

No

**Transgendered people:**

No

**Women and girls:**

Yes

**Young women/young men:**

Yes

**Other specific vulnerable subpopulations [write in]:**

-

**1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?:**

Yes

**If YES to Question 1.1 or 1.2, briefly describe the contents of these laws:**

Section 13(3)(i) of the Charter of Fundamental Rights and Freedoms applies to all Jamaicans but is not widely known, only enforceable against the state and provides for non-discrimination on the grounds of being male or female, race, place of origin, social class, colour, religion, or political opinions. Section 13.1(d) of the 2004 revision to the Civil Service Staff Orders, which has the force of law in Jamaica, provides for non-discrimination on the grounds of age, gender, national origin, race, colour, religious beliefs, political affiliation, disability and sexual orientation. This is not universal, however, and only covers employment in the government service.

**Briefly explain what mechanisms are in place to ensure that these laws are implemented:**

Section 19.1 of the Charter of Fundamental Rights and Freedoms provides for redress against the state for any breaches of constitutional rights, including the grounds for non-discrimination listed above, by way of application to the Supreme Court. Allegations of breaches of the Civil Service Staff Orders protection for non-discrimination are also available through the Supreme Court.

**Briefly comment on the degree to which they are currently implemented:**

The provisions in the Charter of Fundamental Rights and Freedoms and the Civil Service Staff Orders have not been utilized in domestic courts due to their relative novelty and the resistance to litigation, which typifies Jamaican culture.

**2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?:**

Yes

2.1. IF YES, for which sub-populations?

**People living with HIV:**

Yes

**Men who have sex with men:**

Yes

**Migrants/mobile populations:**

Yes

**Orphans and other vulnerable children:**

No

**People with disabilities:**

No

**People who inject drugs:**

Yes

**Prison inmates:**

Yes

**Sex workers:**

Yes

**Transgendered people:**

No

**Women and girls:**

Yes

**Young women/young men:**

Yes

**Other specific vulnerable subpopulations [write in]:**

-

**Briefly describe the content of these laws, regulations or policies:**

Jamaica maintains laws against same-sex male intimacy (Anti buggery laws) prostitution, and illegal drug use. There are also laws against vagrancy, which are used to harass sex workers who ply their trade on the street as well as trafficking laws, which target migrant /mobile populations and drive them underground. The Child Care and Protection Act prohibits minors from accessing reproductive health services without parental consent. A policy exists that prohibits access to condoms in schools and the health services does not support infrastructure to support people with disabilities.

**Briefly comment on how they pose barriers:**

The Anti-buggery laws contribute to a climate of homophobia, which drives MSM underground away from effective prevention, treatment, care and support interventions. They also preclude the distribution of condoms in prisons. The laws against prostitution and drug use also drive sex workers and drug users underground. Minors require parental consent to access reproductive health services, which reduces their numbers in accessing these services.

**3. Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?:**

Yes

**Briefly describe the content of the policy, law or regulation and the populations included:**

Jamaica has a Domestic Violence Act, which allows for victims of domestic violence to get protection orders against their attackers. The new Sexual Offences Act also provides for enhanced legislative protection for female victims of rape which includes marital rape. A Sexual Offenders Registry has also been set up to track the movements of sexual offenders. There is legislation regarding sexual harassment in the workplace related to workplace policies. The Offences Against the persons act considers sexual assaults and rape and protects victims usually women and girls.

**4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?:**

Yes

**IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:**

The Current NSP has a component that is the Enabling Environment and Human Rights anchored in human rights. The National HIV/STI Programme overview states "All human beings including people living with HIV (PLHIV) are entitled to basic human rights..."

**5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, key populations and/or other vulnerable sub-populations?:**

Yes

**IF YES, briefly describe this mechanism:**

National HIV Related Discrimination Reporting and Redress System provides opportunities to report complaints of HIV related discrimination and have the claim investigated. Redress is initiated and followed up by relevant authorities. Concerns are that the system needs refining with more punitive action for perpetrators. The focus of the system is exclusively on issues around HIV, not on human rights.

**6. Does the country have a policy or strategy of free services for the following?**

| <b>Provided free-of-charge to all people in the country</b> | <b>Provided free-of-charge to some people in the country</b> | <b>Provided, but only at a cost</b> |
|---|--|-------------------------------------|
| Yes   | No   | No                                  |
| Yes   | No   | No                                  |
| No  | Yes  | No                                  |

**If applicable, which populations have been identified as priority, and for which services?:**

For ARV treatment: PLHIV and antenatal clinic attendees, HIV exposed babies are prioritized. For prevention services: MSM, OSY, SW, young persons, drug users, prison inmates and OSY are prioritized.

**7. Does the country have a policy or strategy to ensure equal access for women and men to HIV prevention, treatment, care and support?:**

No

**7.1. In particular, does the country have a policy or strategy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?:**

No

**8. Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support?:**

No

**9. Does the country have a policy or law prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?:**

Yes

**IF YES, briefly describe the content of the policy or law:**

The ILO principle which guide the development of workplace policies prohibit HIV screening and the issues are also

addressed by National HIV policy. With the introduction of the National Workplace Policy passed, an end to the still permissible stigmatization and discrimination based on HIV status will result. Regardless of all these policies and laws concerns exist that private entities particularly insurance companies do not conform to these policies/laws. Policies are not enforced across all organizations, as enforcement remains optional.

10. Does the country have the following human rights monitoring and enforcement mechanisms?

**a. Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work:**

Yes

**b. Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts:**

No

**IF YES on any of the above questions, describe some examples:**

a. Public defender, Office of the Children's Advocate, Jamaicans for Justice, Families Against State Terrorism (FAST), J FLAG, JASL all play a roll in promoting and protecting human rights.

11. In the last 2 years, have there been the following training and/or capacity-building activities

**a. Programmes to educate, raise awareness among people living with HIV and key populations concerning their rights (in the context of HIV)?:**

Yes

**b. Programmes for members of the judiciary and law enforcement on HIV and human rights issues that may come up in the context of their work?:**

Yes

12. Are the following legal support services available in the country?

**a. Legal aid systems for HIV casework:**

Yes

**b. Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV:**

Yes

13. Are there programmes in place to reduce HIV-related stigma and discrimination?:

Yes

IF YES, what types of programmes?

**Programmes for health care workers:**

Yes

**Programmes for the media:**

Yes

**Programmes in the work place:**

Yes

**Other [write in]:**

-

14. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2011?:

5

**Since 2009, what have been key achievements in this area:**

The Charter of Fundamental Rights and Freedoms was adopted in 2010 and defined the concept of non-discrimination to include males and females. The draft National Workplace Policy and Political agreement/commitment by the two major political parties are major accomplishment since 2009. The mainstreaming of a gender perspective in the national response and the national anti-stigma campaign are among others. The present political pronouncement by current Prime Minister in 2011 that persons will be included in the cabinet based on merit and not on sexual orientation, as well as, CS lead with a human rights agenda are positive strides in 2009. On-going human rights debate has facilitated more public awareness of the issues and is noted as yet another achievement.

**What challenges remain in this area:**

The legal framework is a hindrance for access to health services for some populations, and the pace of legislative reform is slow. Hence the protection of people from LGBTQ communities is less than adequate. There is a lack of an integrated approach on human rights. More policies than laws exist and it is difficult to ensure compliance and accountability to implement the legislative frameworks as they lack implementation plans. The critical issue of homophobia is not an easy one to change, and media and public attention to buggery have narrowed the human rights agenda to same-sex relationships, which is in need of broadening.

15. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the effort to implement human rights related policies, laws and regulations in 2011?:

5

**Since 2009, what have been key achievements in this area:**

The public face of a human rights attorney taking on discrimination cases has been an achievement and welcomed contribution to the implementation of human rights laws. The redress system that tracks human rights issues enables a level of monitoring the issues. Increased inclusion and engagement of CS along with the inclusion of workplace policies in the public sector companies are strengths. The presence of Jamaicans for Justice in the HIV response, and commitment in the development of a new NSP 2012 – 2017 are programme achievements.

**What challenges remain in this area:**

There is a lack of clarity to implement a clear and focused human rights strategy and framework, and the current NSP is thought to need a clear plan for implementing a step-by-step approach to address these issues. Law enforcement officials could benefit from training in human rights related areas. IMP conditionality cause challenges particularly with the possible reduction in the Global Fund commitment. Other challenges relate to homophobia and a failure of people to see children as rights holders. Ultimately, to move from the point of political declarations to commitments and tangible outputs would be a great accomplishment.

## **B - IV. PREVENTION**

**1. Has the country identified the specific needs for HIV prevention programmes?:**

Yes

**IF YES, how were these specific needs determined?:**

International trends, evidence based programmes and epidemiology data are among some of the strategies used to determine the prevention programme needs. Research from surveys, field-work, surveillance data, M&E data and dialogue with stakeholders who work with key populations also inform prevention needs. The strategic planning processes are also helpful in determining specific populations needs.

**1.1 To what extent has HIV prevention been implemented?**

|   |
|---|
| <p><b>Blood safety:</b><br/>Strongly Agree</p> <p><b>Condom promotion:</b><br/>Agree</p> <p><b>Harm reduction for people who inject drugs:</b><br/>Disagree</p> <p><b>HIV prevention for out-of-school young people:</b><br/>Agree</p> <p><b>HIV prevention in the workplace:</b><br/>Agree</p> <p><b>HIV testing and counseling:</b><br/>Agree</p> <p><b>IEC on risk reduction:</b><br/>Agree</p> <p><b>IEC on stigma and discrimination reduction:</b><br/>Agree</p> <p><b>Prevention of mother-to-child transmission of HIV:</b><br/>Strongly Agree</p> <p><b>Prevention for people living with HIV:</b><br/>Disagree</p> <p><b>Reproductive health services including sexually transmitted infections prevention and treatment:</b><br/>Disagree</p> <p><b>Risk reduction for intimate partners of key populations:</b><br/>Disagree</p> <p><b>Risk reduction for men who have sex with men:</b><br/>Disagree</p> <p><b>Risk reduction for sex workers:</b><br/>Agree</p> <p><b>School-based HIV education for young people:</b><br/>Agree</p> <p><b>Universal precautions in health care settings:</b><br/>Agree</p> <p><b>Other [write in]:</b><br/>-</p> |
|---|

**2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in the implementation of HIV prevention programmes in 2011?:**

6

**Since 2009, what have been key achievements in this area:**

The prevention component has scaled up MSM interventions and positive prevention programmes, improved the targeted community intervention strategy, enabled community ownership of programmes, and increased the number of mass media messages. All while scaling up the involvement of CSOs in the national response. A reduction in HIV prevalence among SW

and the decline in MTCT rates, as well as, the rate of new HIV cases are evident from programme statistics. MARPs testing have increased with inroads being made in the reduction of S&D. Training in gender equality and human rights have been noted, and HFLE has been implemented in 90% of schools in the country. Increased access to ARVs, and the implementation of additional workplace policies are key prevention achievements.

**What challenges remain in this area:**

There is a need for the Government to see HIV as a development issue and to connect the national response to the Country's development economy. The Global Funds' rating of Jamaica as an upper middle-income country has limited financial support with insufficient transition time. Despite many efforts, programme reach and coverage of key population remain a challenge and the proportions of persons who are unaware of their HIV status remain high. Sensitization of and access for persons with disability remain inadequately met needs. There is limited access to condoms and sexual lubricant and OSY interventions need to be scaled-up. The legal framework that criminalizes MSM practices and sex work continue to hamper prevention efforts as well laws that restrict reproductive health services and create barriers for young people. Testing of vulnerable populations need improvement and IEC material that targets those populations are required programme resources.

## **B - V. TREATMENT, CARE AND SUPPORT**

### **1. Has the country identified the essential elements of a comprehensive package of HIV and AIDS treatment, care and support services?:**

Yes

**IF YES, Briefly identify the elements and what has been prioritized:**

Scaling up HIV testing, increased access to diagnostic services, specialized health teams to provide TCS, expanded point of care for CD4 testing comprises the comprehensive package. Along with access to ARVs, PMTC, support for adherence and disclosure. Psychosocial support, contact investigation services, social services for PLHIV and SW are also included.

**Briefly identify how HIV treatment, care and support services are being scaled-up?:**

TCS has been scaled-up through the establishment of more treatment centres, the infusion of PMTCT in family health services, widespread availability and de-stigmatization of HIV testing and the scale-up of ARV treatment. Increased public education to facilitate testing, inclusion of income generating activities and provision of nutritional supplements to enable persons being on treatment. With improved M&E capabilities, getting better data on people on treatment assist with programme scale-up. There have also been attempts at S&D reduction.

1.1. To what extent have the following HIV treatment, care and support services been implemented?

**Antiretroviral therapy:**

Disagree

**ART for TB patients:**

Agree

**Cotrimoxazole prophylaxis in people living with HIV:**

Agree

**Early infant diagnosis:**

Agree

**HIV care and support in the workplace (including alternative working arrangements):**

Disagree

**HIV testing and counselling for people with TB:**

Agree

**HIV treatment services in the workplace or treatment referral systems through the workplace:**

Disagree

**Nutritional care:**

Strongly Disagree

**Paediatric AIDS treatment:**

Agree

**Post-delivery ART provision to women:**

Agree

**Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault):**

Strongly Agree

**Post-exposure prophylaxis for occupational exposures to HIV:**

Strongly Agree

**Psychosocial support for people living with HIV and their families:**

Disagree

**Sexually transmitted infection management:**

Agree

**TB infection control in HIV treatment and care facilities:**

Disagree

**TB preventive therapy for people living with HIV:**

Disagree

**TB screening for people living with HIV:**

Disagree

**Treatment of common HIV-related infections:**

Agree

**Other [write in]:**

Referral for mental health treatment - strongly disagree screening for mental health illnesses - disagree

**1.2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2011?:**

7

**Since 2009, what have been key achievements in this area:**

The country has experienced a reduction in vertical transmission with an annual increase in persons placed in ART due to an increase in the number, availability and accessibility of treatment sites. New line ARVs are now available free of cost. Programme areas such as counselling and testing, nutrition and support have been scaled –up. Paediatric AIDS treatment has improved with the roll out of early infant diagnosis and the promotion of point of care diagnostic testing.

**What challenges remain in this area:**

Care and support services are lacking, and more health facilities need the expertise to diagnose and treat HIV. Treatment facilities and ARV stocked pharmacies are still inaccessible for some persons. Further efforts to desensitize HIV and procure ARV at any pharmacy are necessary for optimal TCS. Some persons have limited access to food required to take ARV medications some of which are unavailable on a regular basis. PLHIVs are not represented at strategy planning sessions aimed at making decisions regarding their welfare and care.

**2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?:**

No

**3. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011?:**

4

**Since 2009, what have been key achievements in this area:**

TSC (OVC) data, although limited, is available from UNICEF's MICS; however, the last MICS was conducted in 2005. There are activities during the period to finalise the 2011 MICS.

**What challenges remain in this area:**

The management of TSC (OVC) remains a national programme gap that requires a holistic approach to their care and support. The absence of a data set that indicates the number of TCS (OVC) reached remains a challenge.

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