

Global AIDS Monitoring Report

2017 NFPB-SRHA

DRAFT

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ALHIV	Adolescents living with HIV
ANC(s)	Antenatal clinic(s)
ART	Antiretroviral therapy
ARV	Antiretroviral
BCC	Behaviour Change Communication
CARPHA	Caribbean Public Health Agency
CCS	Community Systems Strengthening
CDC	Centers for Disease Control and Prevention
CVC	Caribbean Vulnerable Communities
DHIS 2	District Health Information System version 2
EEHR	Enabling Environment and Human Rights
EEHRTWG	Enabling Environment and Human Rights Technical Working Group
eMTCT	Elimination of mother-to-child transmission
FBO	Faith Based Organization
GF	Global Fund to fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People Living with HIV
GOJ	Government of Jamaica
HBI	Home Based Interventions
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HEI	HIV Exposed Infants
HFLE	Health and Family Life Education
HH	Household
HIV	Human immunodeficiency virus
HPP	Health Policy Project
IDP	International Development Partner
IEC	Information, Education and Communication
JaQIC	Jamaica Quality Improvement Collaborative
JFLL	Jamaica Foundation for Lifelong Learning
KP	Key populations
LGBT	Lesbian, Gay, Bisexual and Transgender
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and Intersex
M&E	Monitoring and Evaluation
MARP	Most at Risk Population
MEASURE	Monitoring and Evaluation to Assess and Use Results
MERG	Monitoring and Evaluation Reference Group
MLSS	Ministry of Labour and Social Security
MOEYI	Ministry of Education, Youth and Information
MOH	Ministry of Health
MOT	Ministry of Tourism

MSM	Men who have sex with men
MTCT	Mother-to-child transmission
NASA	National AIDS Spending Assessment
NCDA	National Council on Drug Abuse
NCPI	National Commitments and Policy Instrument
NFPB	National Family Planning Board
NGO(s)	Non-governmental Organization(s)
NHDRRS	National HIV-Related Discrimination Reporting and Redress System
NHF	National Health Fund
NHP	National HIV/STI Programme
NISP	National Integrated Strategic Plan
NPHL	National Public Health Laboratory
NSAP-GBV	National Strategic Action Plan to Eliminate Gender-based Violence
NSP	National Strategic Plan
NWP	National Workplace Policy
OAPA	The Offences Against the Person Act
OSHA	Occupational Safety and Health Department
OVC	Orphans and Other Vulnerable Children
PAHO	Pan American Health Organization
PANCAP	Pan Caribbean Partnership against HIV and AIDS
PATH	Programme of Advancement Through Health and Education
PCR-DNA	Polymerase Chain Reaction - Deoxyribonucleic acid
PEPFAR	President's Emergency Plan for AIDS Relief
PHDP	Positive Health and Dignity Prevention
PIOJ	Planning Institute of Jamaica
PITC	Provider-initiated Testing & Counselling
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PrEP	Pre-exposure prophylaxis
PSIS	Prevention Services Information System
RHA	Regional Health Authority
RNM	Resource Needs Model
SDC	Social Development Commission
SOA	The Sexual Offences Act
SOGI	Sexual Orientation and Gender Identity
SPSS	Statistical Package for Social Scientists
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
STI(s)	Sexually Transmitted Infection(s)
SW	Sex Workers
TB	Tuberculosis
TCS	Treatment, Care and Support
TPDCo	Tourism Product Development Company

TSIS	Treatment Services Information System
UIC	Unique Identification Code
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNJT on AIDS	United Nation Joint Team on AIDS
USAID	United States Agency for International Development
UWIHARP	University of the West Indies HIV and AIDS Response Programme
VCCT	Voluntary Confidential Counselling and Testing
VCP	Voluntary Compliance Programme
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

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I. INTRODUCTION

1.1. Country Profile

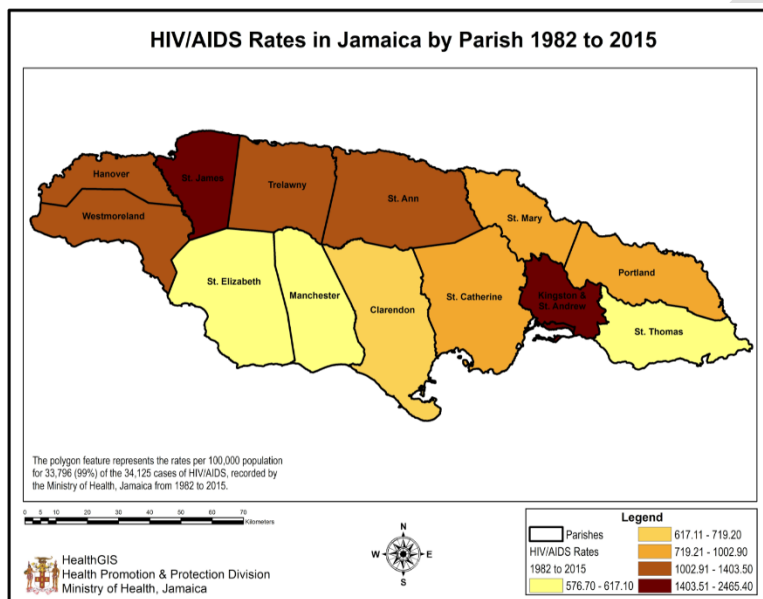
Jamaica is the largest English-speaking island in the Caribbean with a land area of 10,991 square kilometres and a total population of 2,705,800 (Statistical Institute of Jamaica-STATIN 2010 population figures). The island is divided into fourteen (14) parishes. The capital city, Kingston on the southeast coast and the city of Montego Bay on the north coast are the two main urban centres. Jamaica is currently at an intermediate stage of the demographic transition. It has a declining 0-14 age group (9% of total population); and an increasing working age group (52%) and dependent elderly population (11%).

Jamaica's epidemiological profile is marked by a declining burden of communicable diseases and a considerable increase in non-communicable diseases. Recent national surveys among adults 15-74 years of age show an upward trend in the prevalence of overweight and obesity, hypertension and diabetes. The ageing of the Jamaican population has implications for chronic disease prevalence and management, utilization of health services and the social protection scheme. Nonetheless, HIV/AIDS still ranks among the top 10 causes of premature deaths in Jamaica. Furthermore, the combined impact of these epidemiological trends will lead to increasing importance of co-morbid impact of HIV and obesity, hypertension and cardiovascular diseases.

1.2. Overview of the AIDS Epidemic

In Jamaica, it is estimated that 29,000 persons were living with HIV in 2015 (Spectrum Estimate, April 2016, cited in Ministry of Health, 2016) and approximately 16% were unaware of their status. Between January 1982 and December 2015, 34,125 cases of HIV were reported to the Ministry of Health (2015 HIV Epidemiological Update). Of these, 9,517 (28.0%) are known to be deceased. The most urbanized parishes have the highest cumulative number of reported HIV cases: Kingston & St. Andrew – 1,033.4 cases per 100,000 persons, and St. James – 1,515.2 HIV cases per 100,000 persons.

Parishes with significant tourism-based economies have the next highest cumulative number of reported HIV cases since the start of the epidemic: 776.0 cases per 100,000 persons in Westmoreland, 695.6 cases per 100,000 persons in Trelawny, 683.7 cases per 100,000 persons in St. Ann and 679.7 cases per 100,000 persons in Hanover. Therefore, all four parishes that comprise the Western Region are counted among those with the highest cumulative number of HIV cases



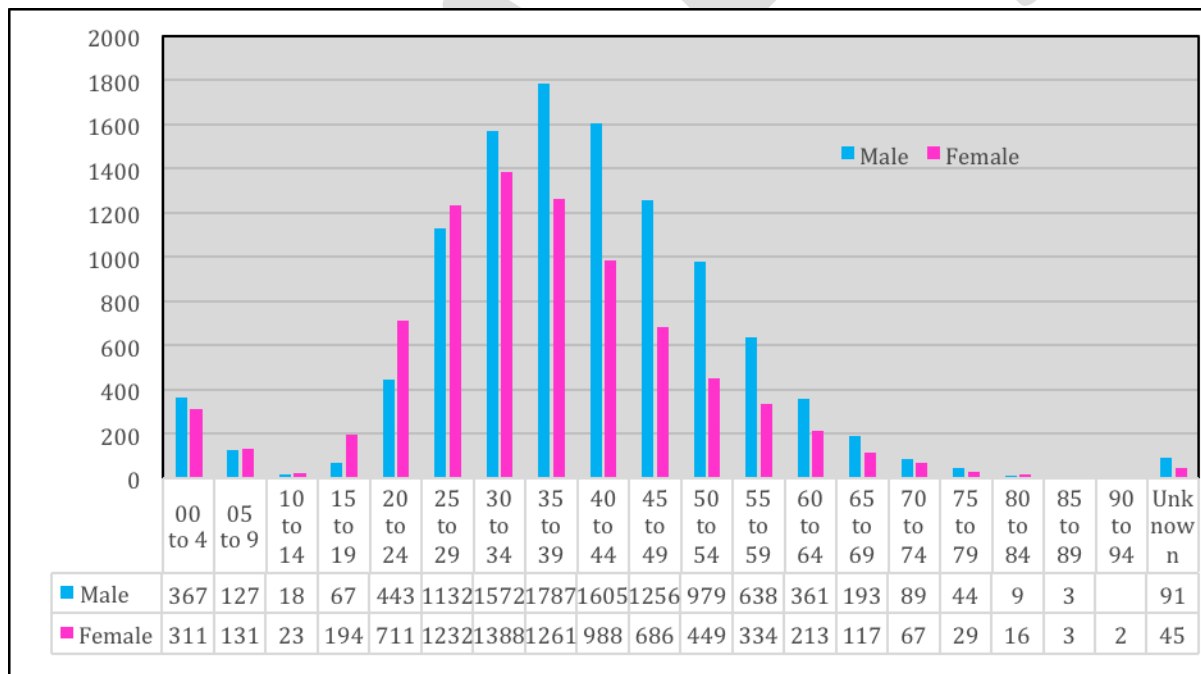
Approximately 75% of all AIDS cases reported 1982 - 2015 are in the 20-49 year old age group and 86% of all AIDS cases reported 1982 - 2015 are between 20 and 59 years old. Cumulatively, there is a steep incline in the number of AIDS cases from 10 – 24 years. The number of AIDS cases reported among 20-24 year olds (1,109) is over 4 times the number of cases reported among 15-19

year olds (250 cases).

There is variation in the gender distribution of reported AIDS cases across the lifespan. Young females account for the larger share of cases in the 10 – 29 age range. In the age group 15 - 19 years old, four times more young women have been reported with AIDS than young men which may possibly be due to testing access. Similarly, young women aged 20 – 24 years old are one and a half times more likely to be infected than males in the same age group. Adult males account for a larger proportion of the cases reported in the 30 - 79 age group. However, the HIV prevalence among young adolescent girls and boys aged 10-14 is equal and is estimated to be 0.1% predominantly the result of mother-to-child transmission of HIV (UNAIDS, 2014, Cited in

Ministry of Health, 2016). In later adolescence (15 – 19 years), there is an estimated increase in HIV prevalence, consistent with the onset of sexual behaviour. By the age of 24, there is a further increase in HIV prevalence consistent with increased sexual behaviour as well as survival and transition of HIV-infected adolescents into the early adult years. Consequently, the estimated HIV prevalence rises to 1% in young women aged 20 – 24 and to 1.4% in young men in the same age the group. In contrast with the estimated HIV prevalence of 0.4 and 0.5 reported in adolescent girls and boys aged 15 – 19 at the national level through the UNAIDS 2014 estimates, the HIV prevalence among gay and bisexual adolescent boys is estimated to be 14% while HIV prevalence in transgender adolescents is estimated to be 27% (National HIV/STI Programme, 2014, cited in Ministry of Health 2016) underlining the extreme vulnerability and urgent need for sustained HIV prevention, treatment, care and support response for these adolescents.

Figure 1: Cumulative AIDS Cases Reported by Age Group and Sex, 1982 – 2015



1.2.1 Risk of Transmission

In Jamaica, HIV transmission is primarily through sexual intercourse. Among all reported adult HIV cases on whom data about sexual practices are available (78% of cases), 95% of persons reported heterosexual practice. Among reported HIV cases on whom risk data are available, the main risk factors are multiple sex partners, history of STIs, crack/cocaine use, and sex with sex

workers. ‘No high risk behaviour’ was reported for a notable proportion of HIV cases and this may represent persons who have one sex partner who was infected with HIV by another partner.

1.3. The National Response

Since 1988, Jamaica has had a national plan to guide the response to HIV and a well-established National HIV/STI Programme and National AIDS Committee. There is participation of key government ministries and civil society in its various programmes. This multi-sectoral response has succeeded in maintaining adult HIV prevalence at a stable level below 2% since the mid-1990s. The Ministry of Health has also integrated HIV prevention, treatment, care and support services into the primary health care system with a concurrent strengthening of the STI care and treatment programmes. Despite Jamaica’s success in addressing the epidemic, HIV and AIDS still have the potential to significantly impede the social and economic development of the country and contribute to the poverty gap.

Through an integrated approach to addressing components of SRH and the HIV response, the Government of Jamaica has demonstrated its commitment to efficiency, sustainability and accountability through a process of public sector transformation, policy and programme harmonization.

The integrated approach increases the focus on leadership, development and governance to facilitate the seamless integration of HIV into SRH policy and programme development and delivery. It responds to the changing policy and fiscal/funding/economic environment and indicates Jamaica’s commitment to the implementation of high impact, cost effective programmes that will result in improved efficiencies and have the potential to scale up SRH responses and reduce the impact of the HIV epidemic¹

1.3.1 Inclusiveness of Stakeholders in the Report Writing Process

¹ Homeless persons/ drug users do **not** specifically refer to injecting drug use, but rather, speaks to homeless persons that use any kind of drug. The increased risk is thus primarily sexual in nature rather than through needle sharing.

This report provides the contextual information against which to frame the country's progress towards the 2020 Fast-Track commitments and expanded targets to end AIDS and uses the commitments as a guide to present the information. It thus supports the indicator performance for the country that is submitted through the online portal for the Global AIDS Monitoring System. While the indicator performance reflects the findings of research, compilation of programme data routinely submitted by stakeholders and Spectrum/EPP Estimates; this narrative highlights the interventions conducted in order to achieve the national outcomes. Challenges encountered, as well as the strategies to address them; along with priorities going forward, have also been outlined within this document to facilitate a deeper understanding of the HIV/AIDS epidemic and national response in Jamaica.

The M&E Units of the Ministry of Health (MoH) and the National Family Planning Board – Sexual and Reproductive Health Agency (NFPB-SRHA) led the report writing process, data entry and national consultations with technical and financial support from partners from the United Nations Joint Team (UNJT on AIDS). Major stakeholder meetings were held with wide representation from across the range of stakeholders in order to review the process, validate the data and then provide feedback on the report. Additionally, there has been separate stakeholder consultations with regards to the National AIDS Spending Assessment, the programme inputs utilized in Spectrum to produce national estimates and the National Integrated Strategic Plan that have also been featured in this report. Stakeholders included representatives from civil society, persons living with HIV and AIDS, representatives of marginalized groups such as men who have sex with men and sex workers, service providers, programme managers, policymakers and providers of technical and financial assistance.

Civil society and government agencies were invited to submit their best practices by completing a response template that underscored the key elements of the intervention or strategy they wished to emphasize, particularly the beneficiary population, results, assessment (if any) and challenges. A consultant and an editing team then reviewed these summaries to ensure that submissions adequately addressed the fields in the template.

II. COMMITMENTS INDICATORS PERFORMANCE (SUMMARY)

<p><i>Commitment 1.</i> Ensure that 30 million people living with HIV have access to treatment through meeting the 90-90-90 targets by 2020</p>	1.1	Percentage of women and men aged 15-49 living with HIV who know their results* (1.5)	<p>Awaiting Spectrum Estimate</p> <p>(2015, HIV EPI Profile/ Spectrum Estimates 2016)</p> <p>Overall: 81% (2014, HIV EPI Profile/ Spectrum Estimates 2016)</p>
	1.2	Percentage of adults and children currently receiving antiretroviral therapy (4.1)	<p>37%: 10680/29,000 (2016 - ARV Programme / Spectrum Estimates 2015)</p> <p>33%: 9764/29,271 (2015 - ARV Programme / Spectrum Estimate)</p> <p>31.3% 9141/29364 (2014 - ARV Programme / Spectrum Estimate)</p> <p>27.4% (8287/30265 -December 2013. Denominator – all persons living with HIV)</p>
	1.3	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (4.2)	<p>58.8% (2016, ARV Database; For persons initiating Jan – Dec 2015)</p> <p>60.1% (2015, ARV Database; For persons initiating Jan – Dec 2014)</p> <p>73.5% (2014, ARV Database; For persons initiating Jan – Dec 2013)</p> <p>89.5% (2013, ARV Database; For persons initiating Jan – Dec 2012)</p>
	1.4	Percentage of adults and children receiving ART who were virally suppressed (i.e. ≤1000 copies)	<p>60.7%: 5846/9622 (2016, ARV Database)</p> <p>45.6%: 4452/9764 (2015, ARV Database)</p>
	1.5	Percentages of people living with HIV with	<p>33.2%: 453/1366 - CD4 <200 (2016, ARV Database)</p>

		the initial CD4 cell count <200 cells/mm ³ and <350 cells/mm ³ during the reporting period	53.4%: 730/1366 - CD4 <350 (2016, ARV Database) 36.5%: 521/1429 (2015, ARV Database) 39.8%: 651/1637 (2014, ARV Database)
<i>Commitment 2:</i> Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018	2.3	Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission	97% - 408/419: (2017, PMTCT Programme Monitoring) 90% - 414/460: (2015, PMTCT Programme Monitoring) 86.4% - 388/449: (2014, PMTCT Programme Monitoring and Spectrum) 88.2% - 410/465 : (2013, Spectrum and PMTCT Programme Monitoring)
<i>Commitment 3:</i> Ensure access to combination prevention options, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations—	3.3A	Percentage of sex workers living with HIV	2.9% of SW (2014, Second generation surveillance) 4.1% of SW (2011, Second generation surveillance) 75% of SW (2008, Second generation surveillance)
	3.3B	Percentage of men who have sex with men who are living with HIV	32.77% of MSMs (2011, Second generation surveillance) 32% (2007, Second generation surveillance)

<p>gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners</p>			
<p><i>Commitment 4:</i> Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020</p>	<p>4.1</p>	<p>Discriminatory attitudes towards people living with HIV</p>	<p>Proportion of men and women 15 – 49 willing to buy vegetables from a vendor they knew was HIV+ Overall: 28.9%; Men: 27% Women: 30.6% (2012, KABP survey)</p> <p>National Target: Men: 30% Women: 40% by 2017 (for composite indicator measuring 5 areas of accepting attitudes)</p>

<p><i>Commitment 5:</i> Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020, in order to reduce the number of new HIV infections among adolescent girls and young women to below 100 000 per year</p>	<p>5.1</p>	<p>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*</p>	<p>Overall: 39% Men: 35.6% Women: 42.8% (2012, KABP survey)</p> <p>40.2%. (2008, KABP) Men: 37.4% Women: 42.3% (2008, KABP)</p> <p>Women: 59.8% (urban); 57.9% (rural) – (2005, Multiple Indicator Cluster Survey)/</p> <p>38.1% of 15-24 year old (2004, KABP) Men: 22.8% Women: 46.7% (2004, KABP)</p>																								
<p><i>Commitment 8:</i> Ensure that HIV investments increase to US\$ 26 billion by 2020, including a quarter for HIV prevention and 6% for social enablers</p>	<p>6.1</p>	<p>Domestic and international AIDS spending by categories and financing sources</p>	<p>Completed (2013-2015, NASA)</p> <table border="1" data-bbox="784 1161 1365 1822"> <thead> <tr> <th>HIV & AIDS Expenditure by Financial Source</th> <th>USD 2013/14</th> <th>USD 2014/15</th> </tr> </thead> <tbody> <tr> <td>Total Spending</td> <td>12,641,382</td> <td>15,073,726</td> </tr> <tr> <td>Public:</td> <td>4,221,876</td> <td>4,093,248</td> </tr> <tr> <td>Percent</td> <td>33.3%</td> <td>27.2%</td> </tr> <tr> <td>International:</td> <td>6,913,285</td> <td>9,335,457</td> </tr> <tr> <td>Percent</td> <td>54.7%</td> <td>61.9%</td> </tr> <tr> <td>Private:</td> <td>1,490,363</td> <td>1,645,020</td> </tr> <tr> <td>Percent</td> <td>11.8%</td> <td>10.9%</td> </tr> </tbody> </table>	HIV & AIDS Expenditure by Financial Source	USD 2013/14	USD 2014/15	Total Spending	12,641,382	15,073,726	Public:	4,221,876	4,093,248	Percent	33.3%	27.2%	International:	6,913,285	9,335,457	Percent	54.7%	61.9%	Private:	1,490,363	1,645,020	Percent	11.8%	10.9%
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<p><i>Commitment 10:</i> Commit to taking AIDS out of isolation through people-centred systems to improve universal health coverage, including treatment for tuberculosis, cervical cancer and hepatitis B and C</p>	<p>11.1</p>	<p>Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV</p>	<p>There were 16 HIV positive incident TB cases detected in surveillance system and all receive ART 2016 (2016 National TB Programme)</p> <p>There were 15 HIV positive incident TB cases detected in surveillance system and all receive ART 2015 (2015 National TB Programme)</p> <p>18 (WHO Estimate, 2014)</p> <p>There were 18 HIV positive incident TB cases detected in surveillance system and all receive ART 2014 (2014 National TB Programme)</p>
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III. 2020 FAST-TRACK COMMITMENTS AND EXPANDED TARGETS TO END AIDS

1.0 Commitment 1: Ensure that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020

The Treatment, Care and Support Unit continues to have an impact on the HIV epidemic through its activities: health products management; co-ordination of access to care and psychosocial support at the various treatment sites across the country; capacity building of various team members involved in the treatment care and support of PLHIV.

1.1 People living with HIV who know their HIV status

HIV testing and counselling were conducted based on the algorithm developed by the NPHL through public and private laboratories as well as outreach activities carried out by VCT/PITC trained personnel. Over 136,000 tests were conducted in the Jamaican Public Health system from January to December 2016. An average of 11,400 tests was done per month. The Provider Initiated Testing and Counselling (PITC) programme aims to provide persons who do not actively seek healthcare with an opportunity to know their HIV status as they access emergency care. On average, 3% of persons tested through this initiative were found to be HIV positive in 2016. Nationally, uptake stands at 25% but varies widely dependent on the type of hospital being monitored.

Table 1: CD4, Viral Load and PCR-DNA Testing for 2013-2015

YEAR	PCR			CD4			VIRAL LOAD		
	2013	2014	2015	2013	2014	2015	2013	2014	2015
RECEIVED	765	1,045	978	10,813	13,038	14,627	10,407	11,490	15,097
PROCESSED	719	891	912	10,234	12,598	14,053	6,969	10,097	14,775
POSITIVE	14	6	11						
REJECTED	21	76	66	423	440	574	433	506	322
REJECTION RATE %	2.7	7.3	6.7	3.9	3.4	3.9	4.2	4.4	2.1

Support

The National HIV Programme provides support for PLHIV through the HIV management team which includes adherence counsellors, social workers, psychologists and a new category of staff: the Case Managers. This cadre of workers assists PLHIV through counselling, psychosocial analysis and mental health assessments. Liaison officers are assigned to each region to help support these and the Contact Investigators' activities. At the National Level a Psychosocial Coordinator and Key Population Quality of Care Officer have been added to coordinate and expand the services offered by these officers.

Challenge

Financial constraints, adjustment and adherence issues have been found to play a major role in patients' adherence. Other patient related challenges include non compliance to safer sex practices, illiteracy, unwillingness to disclose status, lack of motivation and denial. Lack of privacy due to inadequate clinic space often prevents appropriate adherence counselling. Insufficient training of staff and standardized guidelines also present challenges to adherence counselling.

1.2 People living with HIV on ART

Clinical studies have shown that earlier initiation of antiretroviral therapy results in better patient outcomes and has led to Jamaica preparing for the adoption of the WHO 2015 guidelines (cited in Ministry of Health, 2016), which stated that all patients should be offered antiretroviral therapy once diagnosed with HIV. In order to assess the country's readiness for test and treat, a series of consultations were carried out at the parish level to sensitize the regional staff as well as assess the gaps which need to be addressed prior to the introduction of test and treat. The major gaps identified included issues with patient adherence, lack of adequate staff and infrastructure, and supply chain management issues.

Capacity building programmes were developed for the sensitization of support staff. Procurement and supply chain management assessments, done with the assistance of external partners, have identified areas to be strengthened in the process to prevent stock out of critical health products.

The use of the pooled procurement mechanism WAMBO, developed by the Global Fund, offers a source of ARVs at reduced cost and requiring a simpler procurement procedure and hence less lead-time to delivery. The WAMBO platform was introduced to the unit and will be explored as a source for the procurement of Antiretrovirals.

Persons living with HIV have access to 38 treatment sites and antiretroviral drugs are distributed free of cost through public pharmacies and for a nominal fee through eight private pharmacies across Jamaica.

Challenge

Long waiting times at public pharmacies continue to prove challenging to the working PLHIV. The incorporation of dispensation of ARVs by private pharmacies has helped to alleviate this issue.

1.3 PLWHIV who have suppressed Viral Load

An assessment of the feasibility of decentralization of Viral Load monitoring was done in preparation for Test and Treat. The final report indicated that the infrastructure necessary to support this activity was not in place, and the increased number of tests anticipated could be managed by the equipment being used at the central level (NPHL). Specific measures have been put in place to improve the logistics of transportation of samples as well as results. See table 1 for the CD4, Viral load and PCR-DNA Testing for 2013 – 2015

The third iteration of the Jamaica Quality Improvement Collaborative JaQIC 3.0 commenced in October 2015 and served to provide support to clinical care teams to learn and apply improvement methods to achieve the following goals:

1. Improving Virologic suppression of patients on ART
2. Decreasing the number of lost to follow up patients

The initiatives listed below assisted in achieving these goals.

1.3.1. Situation analysis on the options for expanding and increasing access to HIV viral load testing

A situation analysis on the options for expanding and increasing access to HIV viral load testing was supported by the PAHO, a member agency of the UNJT on AIDS. This analysis was provided to the Ministry of Health to support planning and mobilization for the execution of Test and Start in 2017 and onwards. The SPECTRUM Estimates provided data to develop treatment cascades at the national and sub-national levels. Cascades were also developed for adolescents, males and females. The UNJT on AIDS invested in making a difference along the HIV treatment cascade. In this context and through an NGO, adolescents, young women and their families received emotional support and skills for improved adherence to their medication, treatment literacy and other life skills including secondary prevention of HIV.

1.3.2 The Deployment of PHDP Trainees – Community Facilitators

Eleven (11) community representatives of the GIPA Capacity Building Project were also engaged by the NFPB and JN+ and deployed to the Regional Health Authorities as Community Facilitators to support the expanded national focus on community participation in health systems. The community facilitators provided peer support to clients lost to follow-up and helping in the retention of their peers in care with a view to reach viral suppression.

The deployment of the Community Facilitators into the health sector was strategic as it supports the dialogue and follow-up actions on Community System Strengthening (CSS). The community of PLHIV stands to benefit from greater legitimacy as community actors. This experience enhances community engagement and will assist in improving health outcomes, including the achievement of the 90- 90- 90 targets.

1.3.3 Motivational Interviewing Training

In 2016, JN+ provided scholarships for 15 PLHIV to access training in Motivational Interviewing (MI). MI is a *collaborative, goal-oriented conversation style for strengthening a person's own (intrinsic) motivation for change*. In the context of HIV, MI is being used as a tool to motivate PLHIV to access treatment and care, adhere to medication and eventually achieve viral suppression. The training was provided through funding from the Global Fund and facilitated by an internationally certified training consultant.

Best Practices

- A fair and transparent selection process was used to select candidates. The opportunity was made available to all stakeholders not just those affiliated with JN+. The scholarships were advertised widely among sector stakeholders and persons meeting the basic eligibility requirements were encouraged to apply. Short listing and final selections were determined by an independent panel (external to JN+ and including our international development partners)

- All awardees had to be affiliated with and endorsed by a CSO. They were also required to sign a commitment to utilize their newfound skills within the nominating organization or elsewhere in the sector
- The training provided allowed an opportunity for each participant to implement the principles learnt in their daily work activities over a seven month period. They also received coaching and written feedback on practical assessments from their Coach mentor.

Challenges

- The need for greater commitment on the part of participants to ensure that the training opportunity is maximized.
- The need for support from nominating organizations to motivate awardees to persevere and apply themselves even under difficult circumstances.

Way Forward

- More robust advertising of the scholarship to generate more interest and increase the pool of eligible applicants.
- Implement a comprehensive orientation and information exercise for all shortlisted candidates prior to making final selections to ensure that all persons who receive a scholarship are fully au fait with the requirements and are prepared to take on the challenge of training.
- Consistent monitoring and evaluation to ensure objectives are met

There were several notable achievements resulting from the gamut of activities;

1. Doubling of viral load uptake from 13 % to 27%
2. Doubling of viral load suppression from 9% to 20%
3. Efforts to decrease loss to follow up have also yielded success with over 600 patients being returned to care in 2016.

1.4 Late HIV Diagnosis

In recognition of the need to diagnose more PLHIV, outreach testing and PITC were expanded. This expansion included increased training of clinical staff for PITC as well as NGO staff for outreach testing. In 2015, the incidence of HIV amongst hospital admissions was 4%, this is double the rate in the general population. It was therefore recognized that the inpatient population was high burdened and so the PITC programme was expanded in 2016 to address this issue. This has resulted in the reduction in late diagnosis for 2016 with more clients being identified and placed on treatment earlier. Efforts to increase PITC are to include expansion of testing in other out-patient settings such as family planning and dental clinics as well as secondary care out-patient departments.

1.5 ARV Medication stock-outs

Despite efforts to initiate the procurement of ARVs for 2016 in the third quarter of 2015, difficulties with acquisition as well as with suppliers led to low stock and eventually stock-out of some ARVs during 2016, which necessitated alternate regimens for patients. Subsequently, the HST sought technical assistance from our international partner, USAID, to assess our Procurement and Supply Chain Management System (PSM) as well as to provide guidance on improving efficiencies and reducing the occurrences of such instances.

The assessment for these consultation included visits to the MOH procurement unit, the National Health Fund (NHF) warehouses and treatment site pharmacies to observe the logistics of stock management. The major deficiencies identified were:

1. Staff insufficiently trained in stock management (treatment site level)
2. Poor inventory management
3. Lengthy lead time in the procurement process

One of the strengths highlighted through this consultation was the level of intra-regional sharing of limited stock between sites ensuring that all PLHIV received adequate and appropriate ARVs. Recommendations made were successfully implemented.

The civil society also reported these stock-outs and confirmed that scores of PLHIV were unable to source adequate quantities of the regular medications and had to rely on substitutes. As such JN+ established a community-lead ARV monitoring system. A form was developed and shared with PLHIV and other stakeholders within the response. They were requested to complete this form if challenges were experienced when accessing medication. Information from the completed form was then shared with the HIV/STI/TB Unit identifying the affected medication (s) and affected parish/location. Information was also shared with pharmacists regarding the protocols for re-ordering and sourcing ARVS.

Best Practices

- Ground level monitoring of ARV availability to quickly identify areas which are experiencing stock-outs or shortages.
- Regular check-ins with Pharmacies provide them with reminders to re-order stocks and where necessary to seek interim supplies through the Regional Pharmacist.
- Monthly monitoring and reporting on ARV availability has been made mandatory for JN+ employees
- Submission for shortage reports to MOH as soon as such reports are received
- PLHIV educated about the importance of staying on medication even if it means requesting a substitute.

Challenges

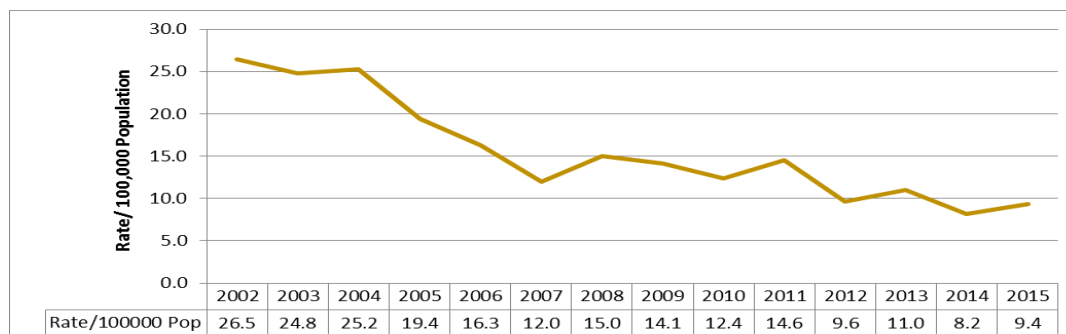
- Except for the JN+ staff who are mandated to monitor ARV availability, many stakeholders do not complete and return the form on a timely basis.

Way Forward

- JN+ has begun implementing treatment literacy workshops to assist PLHIV to understand the importance of adherence and the role/responsibility of the patient in achieving viral suppression.
- Despite improvements in the availability of ARVs JN+ continues to monitor and advise the HST of any challenges.
- Development of a pilot programme to support non-adherent PLHIV to start and stay on treatment.

1.6 AIDS Mortality

Table 2: AIDS Mortality Rate/100,000 Population, Jamaica 2002 - 2015



Source: HATS Database, 2015; STATIN Mid-Year Populations 2002 - 2014

The AIDS mortality rate has declined from 19 deaths/100,000 population in 2005 to just over 9/100,000 population in 2015 which represents a 64% decrease since the inception of universal access to ARVs in 2004. In addition to the introduction of public access to antiretroviral treatment in 2004, scaling up of the national VCT programme and use of rapid test kits allowing for earlier diagnosis, availability of prophylaxis against opportunistic infections and improved laboratory capacity to conduct investigations such as CD4 counts, viral load and PCR tests are believed to have contributed to the decrease in deaths.

2.0. Commitment 2: Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018

2.1 MTCT of HIV and Early Infant Diagnosis

As Jamaica progresses towards the elimination of Mother to Child Transmission of HIV and Congenital syphilis, the data reveals significant strides to improved outcomes. In 2015, 460 HIV positive women had successful deliveries (of total 37,556 live births) and 90% of these women received ARVs during pregnancy and delivery. 98% of the infants delivered received PMTCT interventions and 7 infants have been identified as HIV positive in 2015. This correlates to an incidence rate of 0.19 per 1000 live births, which is less than the eMTCT target of 0.3 per 1000 live births. This also represents a decline in incidences from 2011 when the incidence rate stood at 0.28 per 1000 live births.

PMTCT also remained a high priority for the UNJT on AIDS which provided funding for data quality assessment, which supported the Government's prioritization of areas for improvement in programming and data collection for eMTCT.

2.1.1 Challenges

While each case is unique, there were several common gaps identified among the cases.

- The HIV status of the pregnant woman was not known at the time of delivery. The timeliness of HIV antenatal screens is impacted when the pregnant woman accesses care. If the results of these screens are not available at the time of delivery, mothers require bedside HIV testing. Bedside testing is not available in all maternity units leading to a delay in diagnosis and start of therapy.
- Lack of information about a mother's HIV status at the time of initiation of breastfeeding is a hindrance to her making an informed choice regarding feeding her infant.

- Antenatal and breast-feeding mothers often do not use barrier contraception, allowing for the possibility of transmission of the virus during pregnancy and breast feeding.

Through sensitization of frontline staff to increase awareness of these issues, there have been strides towards narrowing these gaps. The institutionalization of the programme is the focus going into 2017 as the TCS unit seeks to ensure that this programme becomes a normal part of the family health programme.

Table 3: PMTCT data for 2010 – 2015

	2010	2011	2012	2013	2014	2015
# Antenatal Clinic Attendees tested	26,697	27,985	33378 (99%)	35479/33194 (107%)	41990/30933 (136%)	33552/29406 (114%)
LIVE BIRTHS	39,804	39,673	39,348	39,500	34,978	37,556
# HIV+ women delivered	432	417	445	446	431	460
% of women getting ARVs	87%	85%	88%	92%	93%	90%
# of HIV exposed infants	419	413	432	443	422	455
# Infants getting PMTCT interventions	408 (97%)	413 (100%)	422 (98%)	436 (98%)	410 (97%)	446 (98%)
#HIV+ infants	19	10	8	10	4	7
Transmission rate	4.6%	2.4%	1.9%	2.3%	1 %	2%
Incidence of MTCT of HIV/1000 live births in Population [≤ 0.3 per 1000 live births]	0.48	0.28	0.20	0.25	0.11	0.19

3.0 Commitment 3: Ensure access to combination prevention options, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations—gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners

The national response conducted a variety of prevention interventions with key populations in 2016. These are discussed below in addition to prevalence rates and estimates of the size of the populations.

3.1 Estimates of size of key population

Table 4 below shows the size estimates of key populations with latest estimations conducted during 2012 to 2014

Table 4: Estimates of Key Populations

Key population	Size estimation performed (yes/no)	If yes, when was the latest estimation performed? (year)	If yes, what was the size estimation?
a)Men who have sex with men	Y	2014	(4.5% of male population) 33,000
b) Female sex workers	Y	2014	(2.5% of female population) 18,696
c)Homeless drug users	Y	2012	1600
d) Inmates	Y	2013	5000
e)Out of School Youth	Y	2012	141,744

3.2 HIV Prevalence among key populations

Jamaica has features of both a generalized and concentrated HIV epidemic. The estimated prevalence in the general population is 1.6%; however, surveys show higher HIV prevalence in key sub-populations. Surveillance of STI clinic attendees in 2015 indicates that for every one

thousand persons with a STI, approximately 28 were infected. A 2014 survey among sex workers found that 2.9% of female sex workers were HIV infected. In 2011, a survey of 453 men who have sex with men (MSM) found that approximately 1 out of every 3 MSM was HIV-infected. A 2006 survey of prison inmates indicated that approximately 3.3% of inmates are HIV positive.

Table 5: HIV Prevalence

HIV Prevalence	2008/2009	2011-14
ANC attendees (15 – 24 years)	1.1% (2009)	1.1% (2015)
Female sex workers	4.9% (2008)	2.9% (2014)
STI clinic attendees	2.4% (2009)	2.8% (2015)
Men who have sex with men	32% (2007)	32.9% (2011)
Inmates	3.3% (2003)	2.46% (2011)
Homeless persons/Drug users ⁱ	8.82% (2009)	12.9% (2014)
Adults 15-49 years (Spectrum estimate)	1.6%	1.6% (2015)

3.3 Knowledge of HIV Status among Key Populations

During the 2016 reporting period, the national response reached a total of 9,336 MSM (89%) and tested 3,899 (94%) as captured in the Table 6 below. As the transgender target was new to Jamaica, the achievements were minimal in the amount of 734 reached (28%) and 278 (13%) tested. Finally, in relation to female sex workers, the cumulative number reached is 11,819 (104%) and tested 4,678 (108%). These key population were reached and tested through outreach activities, distribution of condoms and lubricants and skills building activities. The information in the table below highlights an obvious challenge in identifying, reaching and testing transgender persons. Of the three key populations, transgenders proved hardest to self-

identify, reach and test. This is an area of concern that will be explored further to establish commonalities within a strategy to identify, reach and test transgender persons.

Table 6: Total Number of Key Population Reached and Tested in 2016

Total Number of Most at Risk Populations Reached and Tested in 2016						
Entity	MSM Reached	MSM Tested	TG Reached	TG Tested	FSW Reached	FSW Tested
NFPB	578	327	16	7	1066	585
NERHA	229	133	21	7	813	309
SERHA	1337	383	118	45	2396	514
SRHA	331	139	7	2	1382	667
WRHA	1539	620	139	8	3140	1315
ASHE	1337	588	148	77	475	110
Children First	1880	1024	53	29	470	350
JASL	2123	750	301	83	1794	713
Jamaica Red Cross	222	82	0	0	59	38
NCDA	94	40	32	14	134	56
Total	9670	4086	835	272	11774	4657

Table 6 also shows the entities that surpassed the others in the achievement of targets: Children First reached and tested the majority of MSM with 1996 and 986 respectively. In relation to transgender, JASL outshone the other entities with 238 transgender reached and 78 tested. Finally, the Western Regional Health Authority was the only Government arm that surpassed all other entities with the number of female sex workers reached and tested with 2870 and 1195, respectively.

For the period 2016, 97% of the reach target was achieved; while the testing target was surpassed by 2% for the Men-who-have-Sex-with-Men (MSM) population. As it relates to Female Sex Workers (FSWs), the reached and tested targets were exceeded by 10% and 13% respectively. Finally, only 33% and 15% of the Transgender (TG) reached and tested target was achieved for the period.

3.4 Coverage of HIV Prevention Programmes among Key populations

During 2016, the national response strategically focused on prevention efforts with three distinct groups: key populations- men who have sex with men (MSM), sex worker (SW) and transgender (TG); vulnerable populations- inmates, drug users and adolescents; and general population. The approaches adapted to reach these key populations include the use of peer support for hard to reach KPs, HIV and Syphilis testing in outreach settings, distribution of condom and lubricants and skills building/empowerment activities.

In addition to the activities of the NFPB, one major focus of the UNJT on AIDS for 2016 was to strengthen the capacity of institutions to deliver combination prevention. Universal access to client centred SRH and HIV services for young people and key populations improved through capacity building at the Ministry of Health, National Family Planning Board, NGOs servicing key populations in the areas of Programme Management, Condom Programming, SRH and HIV Linkage and Integration and SRH advocacy. In preparation for the advocacy programmes the skills of community based organizations and community peer leaders were strengthened to utilize the critical tools such as SWIT, MSMIT, and TRANSIT in developing and implementing advocacy programmes that promote universal access to SRH services for key populations.

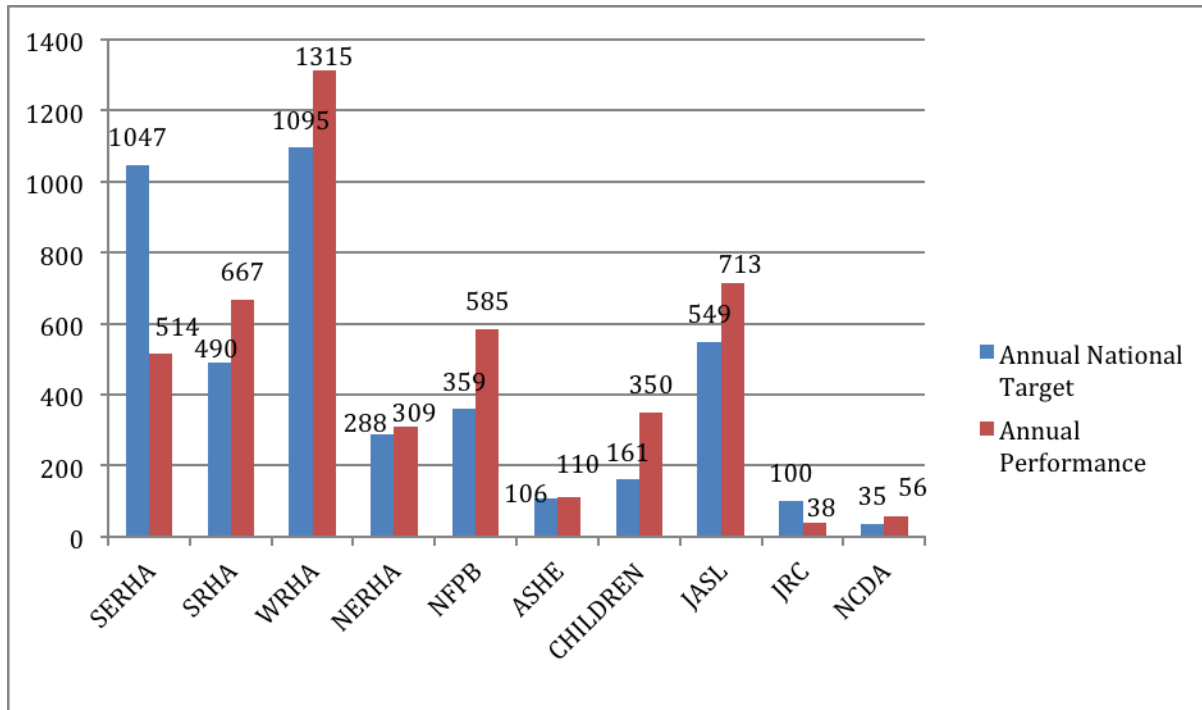
The UNJT on AIDS supported the National Family Planning Board on HIV prevention during the observance of World AIDS Day 2016 by launching with the Government and youth led organizations the HIV prevention campaign which reached over 200,000 persons via social media and other media outlets. The hashtags *#HandsUpJa*, a local take on the *#HandsUpforPrevention* was used in this effort.

The overall strategy to scale up HIV testing and outreach for key populations resulted in execution of four mini-strategies: MSM Strategy, TG Strategy, FSW Strategy and the Inmates Strategy . These were structured around improving the reach and test of men who have sex with men, transgender, female sex workers, while addressing some of the structural determinants.

3.4.1 HIV prevention for sex workers

The number of Female Sex Workers reached decreased by 33.1 % in 2016 (11,774) when compared with 2015 (17,607), while for those tested there was a decrease of 1 % in 2016 (4,657) compared to 2015 (4,704). Although reach and test decreased from the previous year the national targets for reach (11,249) and test (4,230) were surpassed (see figure 2 below). As targets increase annually, this will naturally lead to a decrease if the pool of sex workers is not exponential. The decrease can be attributed to sex workers travelling to different Caribbean islands for work. Also contributing to this decrease in reach and test is an increase in home-based sex work which means that these sex workers wouldn't be reached at street sites and clubs. Finally, violence and police harassment are constant deterrents for conducting sex work.

Figure 2: Female Sex Workers Tested in Comparison to Targets



Previous prevention programmes for sex workers included skill building and empowerment workshops to build FSWs' knowledge, skills and self-confidence to enable them to make informed decisions about their sexual health and wellbeing. However, empowerment and skills building workshops were discontinued due to lack of funding. Nonetheless, successful attempts

have been made by various organizations to maintain aspects of the prevention programme with sex workers despite limited funding. The SRHA and SERHA in an effort to increase awareness amongst FSW about sexual reproductive health issues such as cervical cancer, provided 400 FSWs with pap-smears. NERHA through their sex-workers' community-based intervention has been providing adolescents engaging in transactional sex with SRH information such as the different methods that can be used to prevent unwanted pregnancies and STIs.

The National Council on Drug Abuse in their mandate to reach and test homeless key populations have provided homeless sex workers with nutritional support and social services.

3.4.2. Strategies for FSW Interventions

Interventions with sex workers expanded from addressing issues regarding HIV/ STI to include other reproductive health issues such as screening for cervical cancer. SERHA provided 300 FSW and SRHA provided 100 FSW from Manchester with pap-smears.

Other strategies utilized included the Peer-link Strategy and community-based intervention. NERHA and SERHA through their sex-workers' community-based intervention have found that females were engaging in sex work from their homes. The NERHA and SERHA teams are equipping these young women in the communities with SRH information such as risk assessment and risk reduction, family planning and other SRH information to prevent unwanted pregnancies and STIs.

Challenges

- **Duplication of efforts:** FSW move from one parish or region to another, which leads to multiple agencies reaching and testing the same persons.
- **Identifying new sex work sites:** The traditional sex work sites such as; massage parlours and clubs have not been yielding new FSW.
- **Emergence and identification of new types of sex work sites** – Sex workers have found creative ways of eliminating additional costs associated with service delivery. For

example, sex workers are now operating out of their homes and this presents a challenge to reach and test significant numbers.

- **Use of new technologies** such as social networking which makes it easier to contact their clients without being on the streets and the clubs.
- **Funding for FSW Intervention:** Incentives such as care packages will encourage FSW to utilize other services being offered by the regions such as HIV/Syphilis testing. Funding is also necessary assist FSWs with other psychosocial needs.

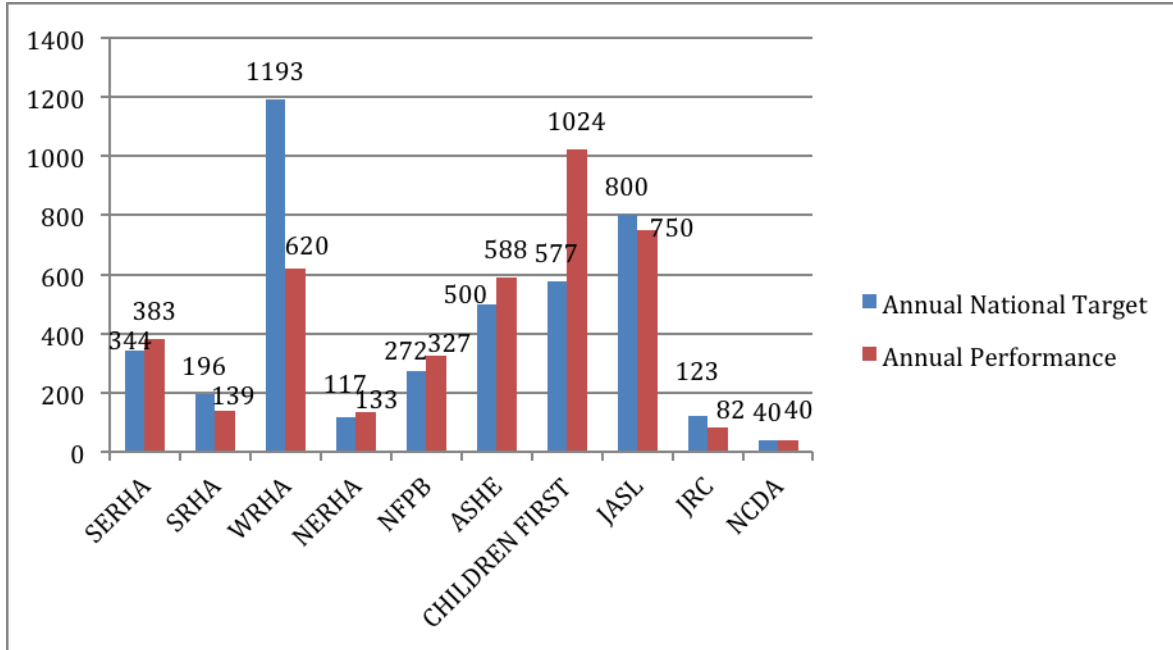
Way Forward

- **Visiting non-traditional sex sites:** Moving from traditional venues to other sites where sex workers operate such as; dances, parties and bars.
- **Increased Partnership with members of the FSW population:** Continued dialogue with members of the FSW community to better understand their needs and to improve delivery of services.
- **Engagement of Peer Links:** Increase the number of sex worker peer links who have superior knowledge of their peers' whereabouts.

3.4.2 HIV prevention for men who have sex with men

There was a 48.7% increase in the number of MSM reached in 2016 (9,670) when compared with 2015 (6,502), while for those tested there was an increase of 90% in 2016 (4,086) compared to 2015 (2,148). Although reach and test increased from the previous year, the national targets for reach (10,439) and test (4162) were not met (see figure 3 below).

Figure 3: MSM Tested in Comparison to Targets



Strategies for reaching MSM

Notwithstanding the achievements with MSMs, to scale up reach and test to MSM the following strategies have been put forward:

1. Home Based Intervention

There has been a shift from MSM empowerment workshops to other educational interventions, which increase participant engagement. The NFPB-SRHA and WRHA have been utilizing Home Based Interventions (HBI) to accomplish this. These interventions cover information, which would have been covered in a workshop such as HIV Basic Facts, STI, Anal Care, Risk Reduction and Adherence. HBI incorporate games and other social activities in a safe space that facilitates more in-depth interactions in a confidential space that encourages sharing. As such, participants are more willing to be tested for HIV and Syphilis. The National Family Planning Board has had 20 home-based interventions with approximately 400 reached and 366 tested.

The NFPB reformed the strategy of workshops and innovatively restructured the content presented to MSM: HIV Basic Facts, STIs, Anal Care, Risk Reduction and Adherence in a concise and exciting format. Incorporating games and other social activities and providing private and comfortable spaces that facilitate testing enabled a wider reach of MSM. It is aimed also at building trust and expanding networks through snow-balling and social media integration. Approximately 20 home-based interventions have occurred with over 200 persons reached through this strategy.

2. Venue Based Intervention

In order to promote and maintain safer sex practices among MSM who already attended home based interventions, the prevention team has conducted a number of formalized venue based sessions that aim to enhance the knowledge given to MSM - making them more effective in impacting behaviour change among their peers. It is also used as a programme to reinforce and further strengthen the SRH information previously obtained.

3. Skills Training & Capacity Building

Three Skills Training sessions were conducted aimed at empowering MSM through practical skills to make them self-sufficient. These are Bartending, Make-Up Artistry and Graphic Design, training 13, 9 and 11 MSM participants respectively. This strategy expanded the team's network making the organization more visible for not just HIV Testing but for impacting the lives of MSM holistically.

Ashe Spectacular Six (S6) Skills Building Series provided training in six different skill areas; Performing Arts, Digital & Video Photography, Studio & Sound Engineering, Entrepreneurship, Interior Décor & Design and Social Media Marketing. Sixty (60) members of the MSM community benefited from the *S6 Skills Building Series*. This led to capacity development that resulted in two members being recruited by Ashe as technical engineers and another as a peer link who assists with social media marketing. Children First had two make-up skills training sessions which benefitted 12 MSM. Also, the National Council on Drug Abuse facilitated the registration of 8 MSM for remedial classes at the Jamaica Foundation for Lifelong Learning (JFLL) while three registered for practical nursing at St. Christopher's School of Nursing. Since

both programmes are one year and eighteen months in length, respectively, its true impact will not be known until 2017 and 2018 respectively.

4. Supporting MSM Events and Parties

Reaching out to MSM requires going into their social spaces and interacting with them where they are most comfortable and together. By supporting these events through donations or ticket sales, the team was allowed entry and hence promoters were more receptive to supporting the prevention initiative. In turn, these gatekeepers will assist in getting persons to agree to be tested. These events are also used to recruit persons for home-based interventions.

5. Social Media Networking through MSM Dating Sites

Through the use of popular MSM Dating sites such as: Jack'd, Grindr, Adam4Adam and LGBT Groups on Facebook and WhatsApp, the prevention team are able to network with various classes of MSM and build relationships so that the team may invite them to home based interventions. This requires outreach officers to create personal profiles and ensure that MSM feel some "human" connection to encourage their attendance to the site based interventions.

6. Utilizing Peer Links for Networking

The identification of influential persons within the LGBT community who have a good network of people are used as peer links to host site based interventions or provide referrals of other MSM. This has yielded a great number of persons attending site based interventions

7. MSM Tool - Card Distribution

All outreach workers are equipped with personalized information cards that resemble a small business card with contact numbers and WhatsApp information to facilitate information sharing when in contact with MSMs. The card includes information linking persons to a private and confidential phone number.

8. Edutainment

Ashe's edutainment intervention, the Attractor Factor programme aided members of the MSM & TG community to explore their personal values and recognize how those values contribute to their behaviours and life styles choices. The objective of the project was to increase the self-efficacy of the participants and empower them to make positive lifestyle choices. The programme was undertaken for a period of 12-15 weeks. Thirty-six (36) persons completed the Attractor Factor 2.0 programme. Participants reported that the Attractor Factor sessions allowed them to recognize the things that affected them and intrapersonal issues that created negative experiences.

Best Practices – MSM Interventions

The utilization of peer links is still the main strategy used to access the MSM community. In addition to the use of peer links, party interventions as well as site-based interventions are being utilized to increase the uptake of HIV testing.

Site-based/venue-based interventions have also been used to address the issues of reducing one's probability of contracting HIV/STIs (Risk Reduction Conversation, condom use, tips about anal health) and Treatment for STIs. Interventions have also addressed the social welfare and needs of the MSM community through the offering of skills training. Through this initiative the Southern Regional Health Authority (SRHA) has assisted 14 individuals with obtaining CSEC subjects and completing college courses. The NFPB-SRHA has helped 34 individuals obtain certification in makeup artistry, bartending and graphic design.

Challenges

- **Greater coordination of use of funds – This will prevent wasting of funds through duplication of effort pursuing programmes that will not yield the desired results.**
- **Insufficient funds:** There are inadequate funds to facilitate interventions necessary to reach the national target for MSM.

Migratory nature of MSM: MSM move from one parish or region to another which results in duplication of efforts. This means that entities working in the response reach some of the same persons in a given week or month.

- **Violence:** MSM were the perpetrators of violent acts in some cases and the victims in other cases, mostly in the urban areas. Threats of violence compound community interventions among the MSM population and also compromise the safety of staff.
- **Incentivized Participation:** MSM have become accustomed to receiving stipends for participating in programmes and have become unwilling to participate in interventions unless monetary incentives or care packages are being offered.
- Stigma associated with sexual orientation – Members of the MSM community are ostracised by the General Population, the Police and Health Care Workers as they seek to find health care, food, shelter and employment. Despite being a Christian society with a high murder rate, Jamaicans snub individuals with an alternate lifestyle. Under the Jamaican law, buggery is illegal. This also contributes to the discrimination faced by members of the MSM community.

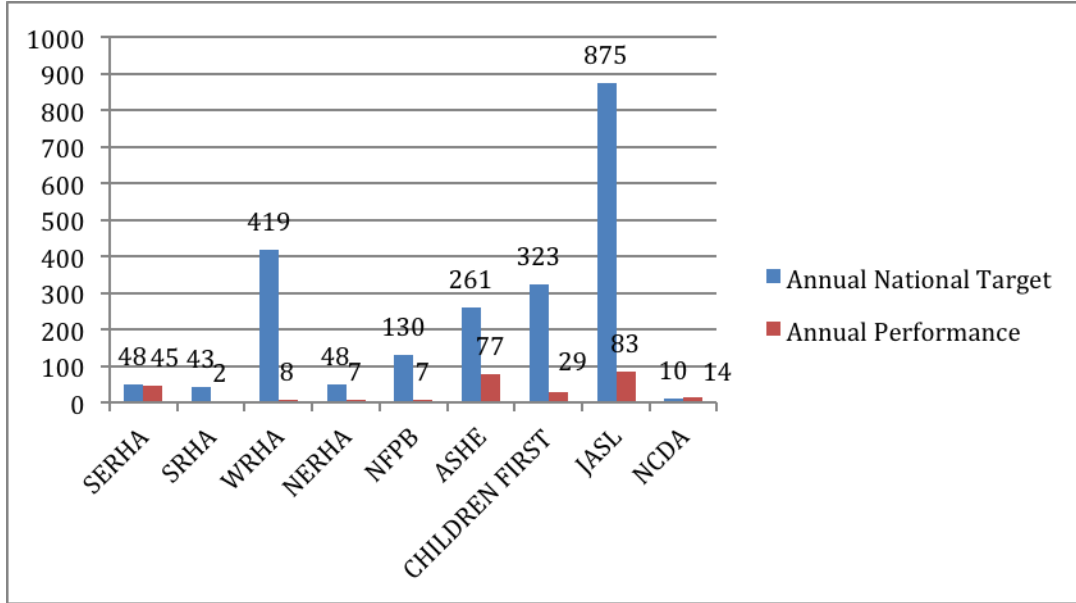
Way Forward

- **Review and revise strategies:** In the absence of increased funding, there is a need for new and creative ways to reach the MSM population, these include replacing workshops with 'lyming' as well as workplace interventions and use the of social media.
- **Communication with members of the MSM population and key LGBT groups:** Continued dialogue with members of the MSM community to better understand their needs and to improve delivery of services.

3.4.3 HIV prevention services for transgender persons

Reaching and testing members of the TG community has been a challenge for all organizations both government and civil society. The annual performance for reach (835) and test (272) fell significantly below the national targets for reach (2669) and test (2157). (see figure 4 below).

Figure 4: TG Tested in comparison to Targets



The Transgender target is also new to Jamaica and a strategy does not exist. The peer link strategy was utilized by the regions to reach members of the TG community. The South East Regional Health Authority (SERHA) held a two day workshop with 40 members of the TG community from KSA, St. Catherine and St. Thomas.

The North East Regional Health Authority, in its efforts to meet TG targets, introduced its outreach officers to Gender Continuum and identifying TG tool (this entails asking a series of questions to ascertain where persons fall on the continuum in terms of gender identity). The theory and the tool were designed to help strengthen the ability of outreach officers to identify where persons are on the continuum in terms of their gender identity when conversing with members of the TG community. Additional training was suggested to help outreach officers develop the skills necessary to help clients experiencing dissonance (emotional conflict

experienced as result of their sex not matching their gender) to think about how they will work through these inner conflicts, knowing that the social, cultural and legal environments do not allow for exploration or expression of gender identity outside of what is considered the norm.

Challenges

- **Members of the TG Community Uncomfortable Disclosing:** the TG population will not self-identify and as such cannot be included in targets. The current environment does not allow for persons to freely express sexual orientations/identities that deviate from what is considered the norm.

Way Forward

- Build capacity of the BCC Team to better understand Sexual Orientation Formation of LGBTQI.
- Prevention Technical Working Group to develop comprehensive national strategy to reach members of the TG community.

3.4.4 HIV Prevention Programmes in Correctional Institutions

The estimated HIV prevalence within correctional institutions of 3.3% (2006) is higher than the national HIV prevalence rate of 1.8% (2013) thus making it imperative to facilitate a prevention, treatment and care programme. The purpose of the Sexual and Reproductive Health Programme in correctional institutions is to identify and provide treatment and care for sexually transmitted infections (STI), specifically: Human Immunodeficiency Virus (HIV), Syphilis and Hepatitis B, as well as to assist the Department of Correctional Services with healthy lifestyle initiatives for the incarcerated population.

Prevention interventions were carried out in five (5) adult institutions throughout the year, namely: Tower Street Adult Correctional Centre (TSACC), St. Catherine Adult Correctional Centre (ST. CACC), Fort Augusta Adult Correctional Centre (FAACC), Horizon Adult Remand Centre (HARC), and Tamarind Farm Adult Correctional Centre (TFACC). Cumulatively, 1,675

inmates were reached with prevention activities. Screening for HIV and other STIs is offered to all new inmates, and those currently housed in correctional institutions. A total of 1,598 were tested for HIV and 1,575 for syphilis. Thirty-six (36) positive cases for HIV and twenty-two (22) reactive cases for syphilis were identified. One hundred and twenty-nine (129) PLWHA received follow-up care such as CD4 and viral load testing, as well as adherence counselling. Throughout the period two hundred and thirty (230) correctional officers were also engaged in sensitization sessions geared at providing knowledge about HIV/AIDS, eliminating the stigma and discrimination associated with the disease, and promoting a healthy lifestyle.

Screening for HIV and other STIs is offered upon entrance of all new inmates, and those currently housed in correctional institutions. The provision of treatment for STIs, including antiretroviral therapy and adherence support for HIV positive inmates also ensues. Throughout the period two hundred and thirty (230) correctional officers were also engaged in sensitization sessions geared at providing knowledge about HIV/AIDS, eliminating the stigma and discrimination associated with the disease, and promoting a healthy lifestyle.

Challenges

- **Prohibiting Condom Distribution in Correctional Facilities:** Although it is known that inmates are engaging in sexual activity officers working with inmates are not allowed to provide them with condoms.
- **Administration of PEP in Correctional Facilities:** The Post-Exposure Prophylaxis (PEP) Guideline, which states that only victims of sexual assault should have access to PEP. In cases where inmates engage in consensual sex and might be at risk they are not provided with the medication.

Way Forward

- **PREP and PEP Programme with the Correctional Facilities:** the Ministry of Health (MOH) is planning to introduce the Pre-exposure Prophylaxis and Post-exposure prophylaxis (PREP & PEP) programme to the general population. After the roll-out of the programme in the general population consideration may be given to the implementation of PREP and PEP within the correctional facilities.

3.5 Participation of key populations in the national response

The following activities served to facilitate the involvement of key populations in the national response.

3.5.1 Consultations for Youth to participate in the UNAIDS High Level Meeting (HLM)

The youth and adolescent technical working group (YATWG) and Jamaica Youth Advocacy Network (JYAN) facilitated the consultative process for young people in preparation for the UNAIDS High Level Meeting using the ALL IN Platform. Through this initiative young persons made contributions to the political declaration process. Key points made during the consultations are:

- International and local stakeholders should view adolescents as a priority population for programming and funding.
- Ensure adolescents with disability and mental health issues are not left behind
- Strengthen health systems to respond to user confidentiality
- Amend laws that restrict adolescent access to contraceptives
- Tap into school based programmes, parenting seminars and faith based platforms with adolescent friendly sensitization
- Improve collaboration with city leaders for a more integrated service provision for adolescents

3.5.2 Greater Involvement of Persons With HIV/AIDS (GIPA)

In 2016, the main tenets of the GIPA approach were further developed in the Positive Health Dignity and Prevention (PHDP) Curriculum, a tool developed for and by the PLHIV population in Jamaica, and used in the GIPA Capacity Building Programme. Modules in Human Rights, Resilient Leadership and Health and Care were developed, increasing the total modules to 17.

The GIPA Capacity Building Programme trained 18 PLHIV and key affected persons in the use of the PHDP curriculum to further strengthen their abilities for community representation in decision-making spaces in the HIV response. The GIPA Capacity Building Programme is an approach to empowering PLHIV (especially key affected populations) by strengthening their abilities for meaningful involvement and participation in the response. It targets PLHIV through a process of mobilisation, recruitment, training, monitoring, and assessment for improved skills and knowledge. The efforts of the GIPA initiative served to drive demand for GIPA-trained PHDP graduates in effective leadership and the participation of people living with HIV (PLHIV) in facility based treatment teams to improve delivery of care to clients and communities.

3.5.3 Kingston Fast Track City Initiative

Through the Kingston Fast Track City initiative the Mayor of Kingston mobilized Jamaica's participation in the 2016 HLM meetings ensuring involvement of local government. The Mayor convened pre- and post HLM consultations with various stakeholders and participated in the HLM Cities event with support at the HLM Cities Event from the National Family Planning Board. The main theme of panel discussion at the event was to highlight the role of city leadership in adopting ambitious fast-track targets, uniting as leaders, and mobilizing necessary resources to accelerate the city's AIDS response. This theme was articulated around three of the seven commitments included in The Paris Declaration in order to achieve the Fast-Track targets, as follows:

- ❖ Ending the AIDS epidemic as a public health threat in cities by 2030 and reaching ambitious goals by 2020

- ❖ Mobilizing resources for integrated public health and development.
- ❖ Uniting as leaders, working inclusively and reporting annually on progress.

The UNJT on AIDS supported consultations for young people, civil society, PLHIV and Government resulting in contributions towards the political declaration. Jamaica's commitment to the 2016 Political Declaration followed high political engagement of key government ministers by the UNJT on AIDS and other high profile partners including the UN SG Special Envoy for HIV in the Caribbean.

Best practices, challenges and next steps

A summary of best practices, challenges and the way forward during 2016 for the prevention and promotion programme is outlined below:

The Best Practices during the reporting period are:

- The interpersonal relationship established from spending quality time with the FSW has led to a degree of openness to receiving care.
- Providing personal care packages for the FSW clients leads to their willingness to receive the HIV & Syphilis test.
- Visiting the sites often have facilitated CSW familiarity with the testing staff and vehicle.

The challenges faced during the reporting period are:

- Getting homeless sex-workers into treatment
- Linking homeless sex-workers to medical care due to available day and hours of service.
- The homeless sex-workers often complain of the hours of service (6 am - 10 am) at the Type 5 Health Centre which is allotted for them to receive treatment and also the availability of the day on which the CD4 testing is done.
- The long wait time at the facility frustrates the homeless sex-workers and they usually leave and cannot be bothered to return.
- The homeless sex-workers cannot be located all the time and if they can be it's on different days.
- Most of the MSM are not willing to participate in HIV programs, unless they are receiving monetary incentives or care packages.

- Target populations have become reluctant to being tested for HIV/Syphilis unless you have something to offer.

Next Steps

Based on the foregoing, the following next steps were identified in an effort to improve access to HIV Testing and Counselling (HTC) services:

1. **Creating a National Transgender Strategy** – As the transgender target is new to Jamaica; the 2016 reporting period showcased obvious challenges to meeting this group. As such, the creation of a TG strategy is necessary to bolster efforts to effectively target this population.
2. **Strengthening the synergies between Prevention and Treatment** – As prevention is the first step in the treatment process, it is important to strengthen the relationship between both, towards the benefit of the clients and the achievement of the 90-90-90 target.

4.0 Commitment 4: Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020

The national response embraced initiatives that targeted gender inequality and violence against key populations, women and girls. This was done mainly through activities that sought to eliminate HIV-related stigma and discrimination in health-care settings, gender based violence and the review and reform of laws that reinforce S&D

4.1 Reducing Discriminatory attitudes towards PLHIV

4.1.1 UNJT on AIDS

The UNJT on AIDS with partners provided technical support to complete the National HIV Reporting and Redress Registry, which list organizations available to guide PLHIV regarding redress. A Report and Redress Directory was also redeveloped in partnership with JN+, and UNDP with funding from USAID, following consultations with multi-sectoral stakeholders. The revised document benefitted from robust consultations to strengthen the redress systems among civil and public agencies and it consists of report and redress entities arranged by sector.

Through a joint proposal with the J-FLAG, print and social media strategic information products were produced for public education and advocacy on diversity and equality. This campaign against stigma and discrimination is intended for use primarily in academic institutions. Another tool, the Stigma and Discrimination Polls, completed in 2016 also provided baseline data to guide advocacy. The polls highlighted public perception on key areas such as abortion, homosexuality, child abuse and access to HIV services.

4.2 Eliminating HIV-related stigma and discrimination in health-care settings by 2020

Programmatic responses to address the above target is listed below.

4.2.1 Setting the Foundation to Meet S&D Reduction Targets by 2020

Background

In 2016 the National Family Planning Board-Sexual and Reproductive Health Agency (NFPB-SRHA) took concrete steps to scale up its efforts towards the elimination of stigma and discrimination in health care settings by 2020. These steps included:

- Initiating a three-year consultation process (2016 to 2018) to develop a referral mechanism between government and civil society partners to optimise health care delivery to key populations
- Forging a partnership with LINKAGES Jamaica to evaluate existing and past Stigma & Discrimination (S&D) trainings of Health Care Workers and
- Restructuring the Enabling Environment and Human Rights Technical Working Group (EEHRTWG) to ensure a specific focus on S&D reduction among its core agenda items

4.2.2 *Referral Mechanism between Government and Civil Society Partners*

The NFPB-SRHA, through its EEHR Unit, began in 2016 a three-year process to develop a protocol to formalise the referral of PLHIV and other key populations to facilitate seamless access to the range of medical and social support services provided through Regional Health Authorities (RHAs), Civil Society Organisations (CSOs), Faith Based Organisations (FBOs) and Social Services Providers. Among the objectives of the Referral Protocol/Mechanism are:

- To establish formal and effective referral and linkage procedures among CSOs, Social Support Services and the formal health system (RHAs)
- To facilitate the incorporation of the referral mechanism into the operational procedures

and systems of care frameworks within health facilities

- To address gaps in the continuum of HIV care in relation to retention in care and adherence
- To standardise guidelines for referrals between RHAs, CSOs and Social Support Services
- To facilitate early access to appropriate services
- To increase positive patient health outcome

In this regard, in 2016 a total of four (4) of the twelve (12) consultations planned over the three-year period between 2016-2018 were completed in addition to a validation session. These consultations allowed stakeholders drawn from government, CSOs and FBOs to provide feedback to inform the finalization of the draft referral protocol documents which were validated in the validation session. It is the intention that the referral protocol will be piloted within the HIV/SRH response and later extended to other illnesses in order to move away from vertical programming which was indicative of the HIV response in the past.

Guiding Principles of the Referral Protocol/ Mechanism

The Referral Protocol is being developed within the context of priority area 3 of Jamaica's National Integrated Strategic Plan 2014-2019, which focuses on the creation of an Enabling Environment and Human Rights. Within this area, there is specific focus on the strengthening of community systems. The community systems strengthening (CSS) framework includes six core components:

1. **Enabling environments and advocacy** – including community engagement and advocacy for improving the policy, legal, and governance environments, and for affecting the social determinants of health;
2. **Community networks, linkages, partnerships and coordination** – enabling effective activities, service delivery and advocacy, maximizing resources and impacts, and coordinated, collaborative working relationships;

3. **Resources and capacity building** – including human resources with appropriate personal, technical and organizational capacities, financing (including operational and core funding) and material resources (infrastructure, information and essential commodities, including medical and other products and technologies);
4. **Community activities and service delivery** – accessible to all who need them, evidence-informed and based on community assessments of resources and needs;
5. **Organizational and leadership strengthening** – including management, accountability and leadership for organizations and community systems;
6. **Monitoring and evaluation and planning** – including M&E systems, situation assessment, evidence-building and research, learning, planning and knowledge management.

When all six principles are fully functional they will contribute to:

- Improved outcomes for health and well-being;
- Respect for people’s health and other rights;
- Social and financial risk protection;
- Improved responsiveness and effectiveness of interventions by communities;
- Improved responsiveness and effectiveness of interventions by health, social support, education and other services.

4.2.3 Evaluation of Stigma & Discrimination (S&D) trainings of Health Care Workers

Recognizing that S&D remain formidable barriers to the uptake of HIV-related treatment, care and support services by PLHIV and other key populations and hence posing a real challenge to the attainment of the WHO/UNAIDS 90-90-90 targets, in 2016 the NFPB-SRHA entered into a partnership with LINKAGES Jamaica for the evaluation of existing and past trainings of Healthcare Workers (HCWs). The evaluation will take the form of a consultancy that will be executed in 2017. However, the conceptual phase of the S&D training assessment consultancy began in August 2016 with the hosting of two key stakeholder meetings consisting of i) multi-

sector partners and ii) HCWs to solicit their involvement in the development of the Scope of Work (SOW) that will guide the Consultancy.

When operationalized, the primary objective of the Consultancy will be to assess S&D reduction training for HCWs in the public health delivery system to identify best practices as well as gaps and challenges, while the anticipated outcome is a set of recommendations resulting in the improvement of the S&D training curricula and methodologies for HCWs.

4.2.4 Restructuring the Enabling Environment and Human Rights Technical Working Group (EEHRTWG)

The mandate of the Enabling Environment and Human Rights Technical Working Group (EEHRTWG), established since 2014, is to function as an independent advisory body to the National sexual health response in the development of strategies and interventions focused on reducing human rights violations and stigma and discrimination. It consists of multi-sector partners, policy experts and key thinkers in Sexual Reproductive Health and Human Rights issues among other priorities:

- ❖ Review and endorse national EEHR standards and tools
- ❖ Provide guidance for the EEHR priority areas to be reflected in the Integrated National Strategic Plan and
- ❖ Set clear deliverables and timelines, in support of effective EEHR agenda implementation

In keeping with its mandate, the leadership of the EEHRTWG endorsed a proposal put forward in 2016 by multi-sector partners that will result in its reconfiguration to ensure a specific emphasis on the realisation of its S&D reduction targets. The proposed restructuring will result in the following:

S&D Focused Meetings

Two of four quarterly EEHRTWG meetings to be convened in 2017 will be specifically focused on S&D-reduction interventions and strategies. The S&D-focused meetings will incorporate discussions on:

- **The development of a comprehensive Redress Framework** which will be informed by the outcomes of on-going quarterly redress consultations which began in 2016, the National HIV-Related Discrimination Reporting and Redress System Steering Committee meetings and
- **S&D reduction Interventions being done in collaboration with multi-sector partners**

4.2.5 Mitigating Risks and Enabling Safe Public Health Spaces for LGBT Jamaicans

Consistent with J-FLAG's strategic objective of increasing public tolerance for LGBT people, the organization is committed to eliminating HIV-related stigma and discrimination health-care settings. Through collaboration with the Ministry of Health, the Regional Authorities and NFPB with funding from USAID, Global Fund, US Bureau of Democracy, Human Rights and Labour and ViiV Healthcare, Equality for All Foundation Jamaica Ltd has been able to implement the Mitigating Risks and Enabling Safe Public Health Spaces since 2011. The project seeks to foster an enabling environment where LGBT people's right to health are promoted and respected and LGBT people are able to seek essential HIV and AIDS services and support free from stigma and discrimination by improving their human rights situation.

Achievements

- Sensitization of healthcare workers across the region around stigma and discrimination and the need for non-discriminatory healthcare services.
- Sensitization sessions with service users within the healthcare facilities
- Meetings with regional health authorities
- Stakeholder meetings with CSOs
- Hosting of Health for All Forums

- Participation in regional and international meetings to highlight the progress being made in eliminating HIV-related stigma – such as Open Society Foundation and GFAN Strategy Meeting on Middle Income Countries, Global Fund Advocates Steering Committee and Strategy Meeting, UN High Level Meeting on AIDS, World AIDS Conference are among a few meetings/conferences attended.
- Creating social media campaigns around reducing HIV-related stigma

Best Practices

- Maintaining partnerships with agencies and partners working to eliminate HIV/AIDS
- Development of situational analysis and other bodies of work through consultancies
- Reports on advocacy forums, residential training sessions as well as project reports highlighting the impact of activities.
- Ensuring all residential trainings and sensitization sessions involve the use of handouts and interactive activities so that the information is not received in a monotonous way. This increases retention.
- The use of annotated agenda when planning and executing residential trainings.

Challenges

- Shortage of healthcare staff affects participation and timely submission of names of healthcare workers to attend training
- High turnover in healthcare system affects continuity of information
- Delays in the procurement process

Way Forward

J-FLAG has expanded its health team and has developed key activities and programmes within the work plan that aims to have significant impact on reducing HIV related stigma in the healthcare system. In addition, the organization plans to strengthen monitoring and evaluation of the project to continue to measure the impact of the work being done. The organization also commits to maintaining partnerships with government agencies, NGOs and the regional bodies to continue streamlining activities to allow for smooth delivery of the work plan.

4.2.6 Confidentiality Initiatives among Healthcare workers

The national response partners addressed stigma and discrimination in the health sector with special focus on confidentiality issues by taking a three (3) pronged approach that included: building awareness of healthcare workers and their clients on a human rights approach to the delivery of health services which included treatment of key populations and PLHIV through stand-alone sessions as well as the integration of sessions into existing meetings; strengthening the MOH Complaint Management System to increase demand for accountability and redress to reduce stigma and discrimination; advocating for a systematic approach to monitoring the implementation of policies, protocols and guidelines.

Addressing issues of confidentiality, The NFPB-SRHA conducted six (6) sensitization sessions with 114 participants (key population representatives, PLHIV, CSO, as well as government policy and decision makers) to build awareness of the Health Privacy Legislation which will form the basis of the Code of Practice Policy Provisions for the health sector in Jamaica to ensure the protection and ethical use of health information and the rights of patients. This initiative is being led by the Informatics Unit of the Ministry of Health with support from the National Family Planning Board-Sexual Reproductive Health Agency. The sessions entailed presentations on the GIPA Positive Health Dignity and Prevention Curriculum, confidentiality issues in the Stigma Index, Updates on the NHDRRS, the Personal Health Information Protection Act/Code of Practice Policy Provisions (PHIPA) and the MOH/RHA Complaint Management System.

The EEHR Unit/NFPB further collaborated with the Investigation and Enforcement Branch and the Health Promotion and Prevention Unit of the Ministry of Health to develop a poster on the standards of confidentiality; that is, the steps to access medical records within the public health sector. Additionally, presentations on stigma and discrimination, a human rights based approach to health care service delivery and the redress framework were delivered to health care workers within the South East and Western Regional Health Authorities during the period under review.

4.2.7 Sensitization of Healthcare workers to the Complaint Management System

The NFPB collaborated with Health Policy Plus and LINKAGES Jamaica to sensitise treatment teams and members of the outreach team of the Southern, North East and Western Regional Health Authorities on stigma and discrimination and the existing redress frameworks including the MOH Complaint Management System. These healthcare professionals interface with most vulnerable communities. It is the intention that these health care workers will in turn sensitise their clients that they have the right to hold health care workers accountable when human rights violations have occurred and they will be better informed about where to seek redress or access services.

4.2.8 NFPB-SRHA/ SDC Partnership

The NFPB-SRHA partnered with the SDC to deliver presentations on sexual and reproductive health to both male and female community members engaged in the SDC's cricket and football competitions orientation sessions. Information sharing and awareness building was provided to the following Ministries during commemorative events:

- Ministries of Justice and National Security - Safer Sex Week 2016
- Ministry of Health – Human Rights Day 2016

4.3 Gender based violence

Gender based violence remained a very topical issue in the national response and as such the following actions were undertaken to eliminate gender based and domestic violence in 2016.

4.3.1 National Strategic Action Plan to Eliminate Gender-based Violence in Jamaica (2016-2026)

Recognising that a coordinated and sustained approach is necessary to address the serious, prevalent and deeply entrenched problem of Gender-based Violence (GBV) The government of Jamaica, through the Bureau of Gender Affairs (BGA) developed a National Strategic Action Plan to Eliminate Gender-based Violence (NSAP-GBV) in Jamaica (2016-2026). The NSAP-GBV 2016-2026, which was presented to Cabinet in 2016 for approval, is designed to prevent

GBV, improve the implementation of laws and services aimed at protecting victims of GBV, as well as to provide adequate support services for survivors. It also aims to standardize protocols for effective data collection tools in order to capture the scope, trends and patterns of GBV to improve future planning and programming. The NSAP also notes the need to pay special attention to strategies aimed at the protection of especially vulnerable groups such as women and girls, the majority of whom are victims of GBV. It further seeks to ensure the protection of underserved communities as well as persons with disabilities and other key populations. The NSAP-GBV is organised around five (5) strategic priority areas, namely; prevention; protection; investigation, prosecution and enforcement of Court Orders; compensation, reparation and redress & protocols for coordination and data management systems.

The NSAP is designed to provide an integrated, multi-sectoral and structured approach to addressing the key issues and challenges in GBV, as it relates to victims, perpetrators, and witnesses of acts of violence. It therefore acknowledges the need to incorporate a socially inclusive, human rights-centred, diverse approach to tackling this endemic problem and it leverages linkages and synergies with national policies and programmes.

4.3.2 Health Policy Plus (HP+) GBV-Focused Interventions

The Health Policy Plus (HP+) project is a five year initiative which aims to improve the enabling environment for equitable and sustainable health services, supplies, and delivery systems by advancing health policy, advocacy, financing, and governance in the fields of family planning (FP), reproductive health (RH), maternal/neonatal/child health (MNCH), and HIV and AIDS. The Health Policy Plus (HP+) project predecessor, the USAID-funded Health Policy Project (HPP), worked in Jamaica for five years to address gender-based violence within the context of HIV.

Building on HPP's work, HP+ set out in 2016 to undertake the following activities:

1. Update the directory of GBV services available, with an emphasis on identifying service providers that are safe for key populations.

2. Review and update the GBV curriculum to include a stronger emphasis on key populations.
3. Train key staff from 12 health care sites in the GBV curriculum using a Training of Trainers approach.
4. Train 30 National Family Planning Board-Sexual Reproductive Health Agency (NFPB-SRHA) Health Promotion and Prevention Unit Staff in GBV and the importance of collecting health facility-level data.

In executing Activities 2 – 4 between October and November 2016, the HP+ designed a GBV training for healthcare workers implementing HIV prevention and treatment programmes for key populations (KP) men who have sex with men (MSM), sex workers (SW), transgender persons (TG), people living with HIV (PLHIV) and women and girls in high risk environments) and other gender and sexual minorities (GSM) in Jamaica. In total, 69 persons were trained in four workshops representing 86.25% of the targeted persons.

The overall aim of the training was to assist each participant to develop a “Standard Operating Procedure for Prevention and Response to GBV” and to address the problem of GBV within their work environment. It assumed the participant had prior sensitisation on GBV, HIV 101 and Sexual Health including sexuality.

The key learning objectives included:

- Ability to define gender-based violence
- Deconstruct the myths and realities surrounding GBV and understand that GBV also affects males due to gender norms
- Discuss the prevalence of GBV and its impact on the health of key population, to include women and girls’ reproductive health
- Understand sexuality as a comprehensive construct
- Identify and Manage GBV
- Understand how gender norms and relations can either perpetuate or help to eliminate gender-based violence

- Understand the emotional and social consequences of SGBV on GSM
- Apply Human Rights and Ethical Principles to GSM Care and Services

Some key issues arising from the training from the perspective of the participants include the following:

1. GBV in GSM relationships in Jamaica is real and may be as high as among the general population. Some sub-groups of GSM such as transgender appear to suffer higher levels of GBV.
2. GBV among GSM, although similar to the underlying issues related to GBV among heterosexuals, has some unique differences including the types of abusive tactics used and the context of stigma and discrimination faced by GSM.
3. GSM survivors of GBV can also face discrimination within their own communities.
4. GSM survivors of GBV are less likely to seek services from the health sector and law enforcement and are more likely to rely on informal social support
5. Health Care Workers (HCWs) are in a unique position to provide service that is not rooted in an atmosphere of care and understanding. The kind of harm done by some HCW is antithetical to trauma-informed practice.

4.3.3 Gender Based Violence and Legal Literacy Training Work shop

Background

Through the support of the UN Trust Fund to end violence against women and girls, facilitated through the Jamaica AIDS Support for Life (JASL), JN+ hosted a five-day training workshop under the theme “Responding to Violence against Women in the Context of HIV”. Eighteen (18) women living with HIV benefitted from the training, which provided information on:

- GBV and its various manifestations,
- The link between GBV, gender and HIV
- Human rights, legal literacy and advocacy
- Communication, disclosure and empowerment

Best Practices:

- The sessions were highly interactive as facilitators used participatory exercises to unpack complex legal information which allowed participants to have a better understanding of the existing legal provisions to protect them
- Peer led empowerment of participants through sharing of personal experiences of overcoming GBV.

Challenges:

- Mobilizing participants who were willing and available to attend all five days
- Unavailability of in-session psychosocial support for participants

Way Forward

- Making psychosocial support available to members who experience GBV
- Conduct on-going legal literacy and human rights training with members

4.3.4 GBV as Crosscutting HFLE Review Process

Under the Ministry of Youth and Information, violence and gender-based violence were included as crosscutting issues in the review process of the HFLE, 2016. Additionally, the Ministry trained teachers in GBV in all of its regions in partnership with Bureau of Women's Affairs. Eve for Life facilitated trainings with teachers in St. James, while the Bureau of Gender Affairs facilitated trainings on GBV in other regions some of which were conducted as a part of Safer Sex week 2016 activities. Also captured under the MoEYI's activities, ASHE conducted an Edutainment piece and small group sessions with students. The Bureau of Gender Affairs also conducted sessions on gender-based violence. 240 primary and secondary HFLE Teachers/Master Trainers were trained in sexuality education. Eighty percent (80%) of persons trained demonstrated increased knowledge and comfort to teach sexuality-related HFLE lessons

4.4 Review and reform of laws that reinforce S&D

4.4.1 Public Consultation to Revise the National HIV/AIDS Policy

Background/Rationale

The Government of Jamaica, via Cabinet Decision No. 22/15, approved the revision of the National HIV/AIDS Policy in June 2015. In a Post Cabinet Press Briefing to announce the approval, the then Minister with responsibility for Information stated that “the HIV Policy revision would provide an enhanced framework, direction and guidelines for interventions to people infected with, and affected by HIV”. The former information minister also indicated “there is...new evidence that it has become necessary to develop a policy that will guide implementation of HIV interventions, particularly among key population groups”. This has become necessary as the epidemic has become increasingly concentrated among certain groups since 2005 when the Policy was first developed and approved (Jamaica Observer, 2015). Given that the Policy has not been revised since 2005, it is imperative that the Policy is updated to reflect achievements to date, including the integration of family planning, maternal and child health, sexual and reproductive health and HIV into primary health care as reflected in the NISP 2014-2019 as well as other critical areas of concern to the success of National HIV Response.

Since the revision of the National HIV/AIDS Policy was approved, the NFPB-SRHA worked earnestly in 2016 to implement the recommendations of the Human Resource Committee (HRC) of Parliament. The first task included convening a meeting in February 2016 of the Policy Review Steering Committee, the mechanism to ensure key stakeholder involvement in the revision process, to discuss the HRC recommendations and develop a Plan of Action. Among the recommendations was that a partnership be forged with the Social Development Commission (SDC) for the execution of island-wide public consultations to facilitate discussions with different target groups on matters related to the amendment of key pieces of legislation that could impact the implementation of the Policy. Established as Jamaica’s principal community mobilisation and organisation agency in 1965, the partnership with the SDC was recommended by the HRC as the best-fit, due in large part to the SDC’s reach in communities island-wide.

Achievements

On May 5, 2016, the NFPB-SRHA/SDC partnership for the execution of island-wide public consultations was formalised with a Memorandum of Understanding (MOU) Signing Ceremony, which signalled the official start of the series of consultations. Thirteen (13) public consultations were held between May 10 and June 2, 2016, to discuss the revision and development of the National HIV/AIDS and SRH Policies, respectively. Approximately 793 participants consisting of a mix of government, and non-governmental organisations (NGOs), community based organisations (CBO's), schools and churches participated in the consultations. The participants were drawn from 257 communities across the island, a significant percentage of whom also constituted the island's Community Development Councils (CDCs) ensuring that a wide cross-section of Jamaicans were reached during the consultations.

Figure 5: Participation in Public Consultations by Parish: Youth and Gender Composition

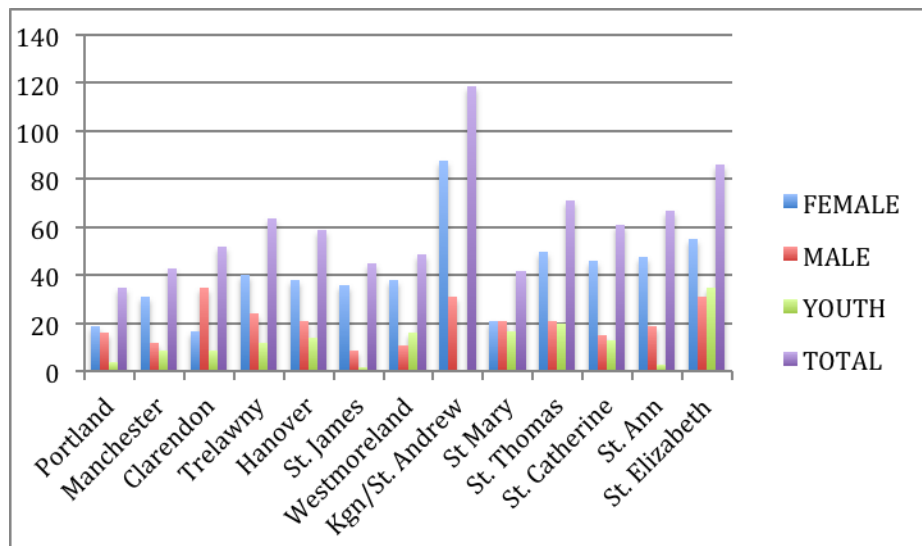
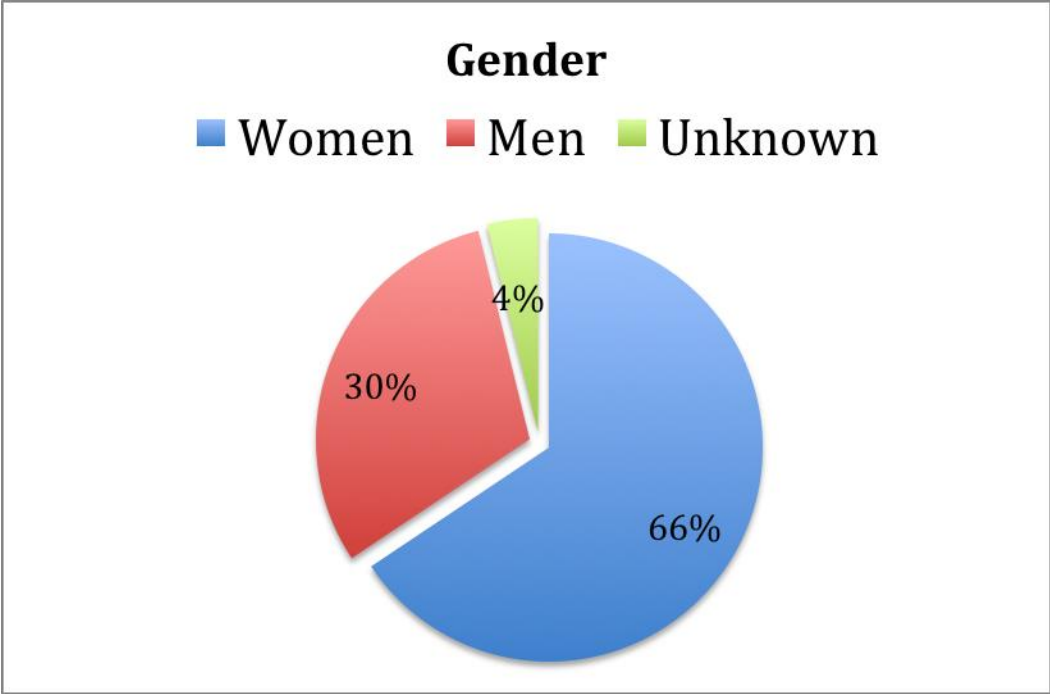


Figure 6: Participation: overall gender composition






YOUR INPUT IS IMPORTANT

BE THERE TO SHARE

PUBLIC CONSULTATION SERIES

Revision & Development of the
National HIV/AIDS & Sexual & Reproductive Health Policies

	Parish	Consultation Date	Venue and Time
1.	Portland	May 10, 2016	Christ Anglican Church Hall in Port Antonio (1:00 pm)
2.	Manchester	May 11, 2016	Parish Church Hall in the Town of Mandeville (10:00 am)
3.	Clarendon	May 12, 2016	St. Gabriel Anglican Church Hall in May Pen (1:00 pm)
4.	Trelawny	May 16, 2016	Falmouth Town Hall (3:00 Pm)
5.	Hanover	May 17, 2016	Global Villa, Lucea (10:00 am)
6.	St. James	May 18, 2016	Calvary Baptist Church, Montego Bay (10:00 am)
7.	Westmoreland	May 19, 2016	The Source, Lot 224 Barracks Road Savanna-la-Mar (10:00 am)
8.	Kingston & St. Andrew	May 25, 2016	Emmanuel Apostolic Church 12 Slipe Road, Kgn.5 (Cross Rds-2:00 pm)
9.	St. Mary	May 26, 2016	Port Maria Civic Centre (10:00 am)
10.	St. Thomas	May 30, 2016	St. Thomas Anglican Church Hall in Morant Bay (11:00 am)
11.	St Catherine	May 31, 2016	Arian's Restaurant, Shop 1-Spanish Village, Spanish Town (10:00 am)
12.	St. Ann	June 1, 2016	Sandcastles Resort Main Street, Ocho Rios (10:00 am)
13.	St. Elizabeth	June 2, 2016	SDC Office-Centre Road, Santa Cruz (2:00 Pm)

Public Consultation Schedule

The objectives of the consultations were:

- To provide an opportunity for citizens to improve their understanding of the HIV epidemic and the role of citizens in working together as partners in the HIV response for the purpose of reducing the HIV prevalence, stigma and discrimination
- To solicit feedback from citizens to guide the development of a Sexual and Reproductive Health (SRH) Policy
- To solicit feedback from citizens to guide the revision and updating of the National HIV Policy

The participants provided crucial feedback on the salient areas of the Policy including the six policy areas and the need for legislative and policy amendments for its effective implementation following the completion of the revision process. By way of an example, The Offences Against the Person Act (OAPA) and the Sexual Offences Act (SOA) were widely debated as key pieces of legislation that should be amended.

The vast and robust feedback from the public consultations was captured in thirteen (13) individual parish reports and a summary report synthesizing the outcomes of the parish reports as well as evaluation survey instruments, which were analysed using the Statistical Package for Social Scientists (SPSS). These findings will inform the finalisation of the revision of the National HIV/AIDS Policy.

Challenges

Owing to the sensitive nature of the discussions surrounding legislative reform including proposed amendments to the Offences Against the Person Act and the Charter of Fundamental Rights and Freedoms, specific measures were required to ensure the effective management of the consultations.



The Way Forward

The finalisation of the revision of the National HIV/AIDS Policy will involve specific steps to include comprehensive reviews of the public consultation reports as well as the policy and legislative environment, the updating of the Policy Concept Paper, the finalisation of the HIV/AIDS Policy and the validation of the Policy document through a series of validation meetings. Similarly, the public consultations, will in large part, serve to inform the development of a Situation Analysis and Concept Paper that will be presented to Cabinet seeking approval for the development of the SRH Policy.

4.4.2 Reviewing and reforming laws that reinforce stigma and discrimination, including on age of consent, HIV non-disclosure, exposure and transmission, travel restrictions and mandatory testing.

Consistent with J-FLAG's strategic objective to create the foundation for legal reform, several of the activities across their different projects were geared towards facilitating the amendments to laws and policies as well as the development of same to better protect the rights of all persons, particularly LGBT persons, women, PLHIV and other vulnerable groups. Discriminatory laws, and the lack of protective laws, represent a significant gap in ending stigma and discrimination against vulnerable groups. Cognizant of this, JFLAG's activities have been wider in their consideration of legal and policy gaps and have sought to raise awareness about same among different populations.

Achievements

- Convened meetings with policymakers, Parliamentarians, Government agencies to raise awareness about the impact of homophobia and transphobia on the lives of LGBT persons, particularly LGBT youth. These meetings highlighted particularly problematic areas of law and policy.
- Conducted research on the impact of the buggery law, as far as rates of arrest, charges, prosecutions and convictions are concerned.

- Conducted research to identify and clarify the varied laws and legal doctrines, which affect the lives of LGBT Jamaicans, beyond the buggery law.
- Developed a human rights curriculum to standardize human rights trainings across civil society.
- Conducted training of trainers around the human rights curriculum.
- Conducted human rights and gender and sexuality diversity sensitization sessions with healthcare workers and service users.
- Conducted human rights sensitization and legal literacy sessions with LGBT youth and LBT women to increase their awareness of the legal situation and build their capacity to advocate for more protective laws.
- Participated in the 4th review of Jamaica's compliance with the International Covenant on Civil and Political Rights by the Human Rights Committee, securing recommendations from the treaty body for the government to address violence against women, gender discrimination, stigma and discrimination related to HIV and discrimination on the basis of SOGI and disability.
- Advocated for the re-establishment of the Joint Select Committee reviewing the Sexual Offences Act and other related Acts through its membership in VERJ.

Best Practices

- J-FLAG's work benefits from the expansion of the focus to include the impact of laws and policies on LGBT Youth, LB women and trans persons. This has allowed us to diversify our approach.
- Using accessible language and relatable examples when sensitizing persons around stigma and discrimination generally reduces discomfort around discussions around GSD.
- Ensuring all residential trainings and sensitization sessions involve the use of hand-outs and interactive activities so that the information is not received in a monotonous way. This increases retention.
- The use of annotated agenda when planning and executing residential trainings.
- Engaging media, policymakers and parliamentarians on issues of national development not limited to HIV and LGBT rights. Persons are more likely to listen to you when you are not too narrow in your focus.

- The use of social media to share research findings in attractive and simple ways.

Challenges

- Procurement processes can delay the implementation of activities because of the bureaucracy required.
- More funding is required to address challenges specific to LB women and trans persons.

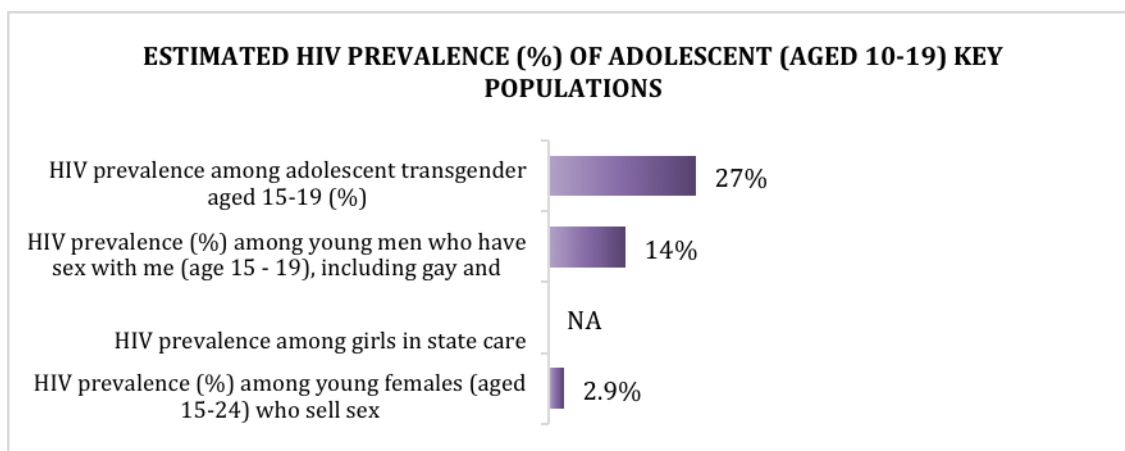
Way Forward

Following on the research done related to the diverse laws impacting the lives of LGBT persons, focus will be placed on advocacy for the creation of comprehensive anti-discrimination legislation. JFLAG has entered a submission to the re-established Joint Select Committee reviewing the Sexual Offences Act and related Acts, with a view to reviewing some of the legal barriers to access to SRH services as well as addressing the gaps within the legislation. There will be more sensitization among the LGBT community around the need to address not just the bugger law, but other problematic areas of law so that they can participate in the advocacy efforts. JFLAG is also currently working with the Ministry of Foreign Affairs and Foreign Trade to implement some of the recommendations coming from the Human Rights Committee review.

5.0 Commitment 5: Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020, in order to reduce the number of new HIV infections among adolescent girls and young women to below 100 000 per year.

The HIV response renewed its commitment to adolescents and youth as a priority population in 2016. While the HIV prevalence among adolescents (10-19) falls well below that of the adult population at 0.5%, some groups are disproportionately affected by the epidemic. These include adolescent transgender females, MSM, Females Sex Workers (age 18 and 19) and young girls that are sexually exploited. This mirrors the adult epidemic and further reinforces the notion that risky sexual behaviours that result in HIV transmission often begins from adolescence. It is therefore imperative that prevention programmes are designed to reach vulnerable young people.

Figure 7: HIV Prevalence Among Adolescence



5.1 HIV Prevention among youth populations

Specific initiatives captured under HIV Prevention among youth populations are listed below

5.1.1 UNWOMEN Gender Empowerment Project

The National Family Planning Board (NFBP) with funding from the UN Women Fund for Gender Equality (UNFGE) has been implementing the Gender Empowerment Project, which is designed to improve Sexual and Reproductive Health of Adolescent Girls and Young Women through Empowerment and Reduction of Gender Inequalities. The project was implemented in the communities of Salt Spring, St James; Tel-A-View and Jones Town, Kingston and St Andrew; Santa Cruz, St Elizabeth and Savanna-la-Mar, Westmoreland. A total of 208 women ages 15 to 24 participated in the programme. Analysis of pre and post-test results showed improvement in areas such as self-perception, knowledge of contraceptive methods, HIV prevention, gender norms, stigma and discrimination and attitudes towards parenting. At the end of the programme 83 persons received HIV testing and 32 were using contraceptive methods. Only 7 females had repeat pregnancies. Twenty (20) were employed and 8 were continuing their education.

5.1.2 All In #EndAdolescentAIDS – Phase 3

All In to #EndAdolescentAIDS is a response to the inequity in progress towards the global goals of the AIDS response. It is a collaborative platform aimed at driving better results for adolescents through critical changes in programmes and policy. All In seeks to engage adolescents and unite stakeholders to accelerate reductions in AIDS related deaths by 65% and new infections in adolescents by 75% by 2020. The initiative is led by the UN joint team on AIDS and the Ministry of Health and focuses on four key areas:

1. Engage, mobilize and support adolescents as leaders and agents of social change.
2. Sharpen adolescent elements of national AIDS programmes through improving data collection, analysis and utilization to drive programming and results.
3. Foster innovation in approaches to improve reach to adolescents and increase impact of prevention, treatment and care programmes.
4. Mobilize global, regional and country-level advocacy to firmly position adolescent AIDS on the agenda, communicate needs and successes effectively, and mobilize and direct resources towards effective and efficient programmes for and with those adolescents most in need.

5.1.3 UN Joint Team on AIDS

The United Nations Joint Team on AIDS selected the All In Platform as a key area for support. Activities focused on strengthening the evidence base for strategic adolescent and youth-centred prevention and treatment interventions, JT support also ensured adolescent and youth participation in all aspects of ALL IN implementation. With the government's leadership, the UNJT on AIDS facilitated the implementation of phases 1 and 2 of the All In Platform as well as initiation of Phase 3. Consequently, a draft action plan to prioritize adolescent-focused interventions was produced and is to be finalized and implementation initiated in 2017. The action plan is grounded in the synthesized evidence resulting from the previous rapid assessment, which highlighted similar risks for HIV transmission for adolescent boys and girls. Previously the risk for adolescent boys was underestimated. This data has already generated investment by the Global Fund to address some key areas of need for adolescent key populations and ALHIV. Additionally, the Ministry of Health adjusted its monitoring framework to include reporting on indicators relevant to the adolescent age groups. The findings from the assessment have also strengthened the Ministry of Health's proposal to parliament to review laws that restrict adolescent access to sexual and reproductive health services including HIV testing, condoms and other contraceptives.

Key finding from All In

- HIV prevalence among young adolescent girls and boys aged 10-14 is equal and is estimated to be 0.1%
- The estimated HIV prevalence in young women aged 20 – 24 is 1% and 1.4% in young men in the same group.
- The number of adolescents and youth living with HIV was estimated at 685 adolescent girls (aged 10 – 19) and 825 adolescent boys
- HIV prevalence among gay and bisexual adolescent boys is estimated to be 14%
- HIV prevalence in transgender adolescents is estimated to be 27%

Lessons Learnt

- There is a need for urgent implementation of better strategies to identify and link behaviourally-infected adolescents to HIV testing and treatment and care services as well as the critical complementary protection, care and support services.
- Coverage of HIV testing and counselling among sexually active adolescents needs to be scaled up. Only 30% of sexually active adolescent girls aged 15 – 19 years and 18% of adolescent boys have tested for HIV compared to a target of 75%.
- The current legislation regarding the age of consent for service delivery for adolescents, in particular HIV testing and counselling as well as sexual and reproductive health services including contraceptives, presents a barrier for effective interventions.
- Cash transfers have been found to have significant influence on preventive behaviour, lowering transactional and age disparate sex among adolescent girls in vulnerable households receiving them.

There is a need for strengthening and sustaining of comprehensive protection, care and support interventions and programmes for adolescents.

Phase three of All In was designed to address the bottlenecks and barriers to effective prevention, treatment, care and support services for adolescents that are most vulnerable. These priority groups include teen parents, children in state care, adolescents living with HIV (ALHIV), young MSM, young FSW and young TG. A national multi-sector stakeholder consultation with representation from government, International Development Partners (IDP), civil society and young people was convened in October 2016 to facilitate action planning for a strategic way forward in improving HIV programmes for adolescents and youth.

The primary areas of focus included:

- 1. Prevention programmes for adolescents-** access to condoms and other contraceptives, strengthening knowledge and information and HIV counselling and testing
- 2. Treatment care and support-** Access to timely treatment, adolescent friendly treatment sites and adherence support

3. Mental health and substance misuse- Psycho-social support services for adolescents, improving access to mental health services, improving education and availability of information about substance misuse



Highlights from the All In Phase Three action-planning meeting.

5.1.3 Training of Health Care Workers in adolescent standards of care

The lack of adolescent friendly health service delivery has been highlighted as a gap in delivering quality service to adolescents living with HIV (ALHIV) and those most vulnerable. The Ministry of Health therefore set out to address these gaps by developing adolescent standards of care for public health facilities. Twenty-two health professionals from primary care public health centres and hospitals in each parish were trained through a series of two-day

parish-level training workshops. The effort represented technical and administrative collaboration between the Adolescent Health Unit and the HIV All-In programme in the MoH and was supported financially by two of the Ministry's United Nations partners – United Nations Population Fund (UNFPA) and United Nations Children's Fund (UNICEF).

The overall goal of the parish-level workshops was to sensitize health care workers and providers to the adolescent health standards to improve service to adolescent clients. The expectation was that, at the end of each 2-day workshop, participants would be able to:

- Describe the process adopted by the Ministry of Health to develop the Standards for adolescent health;
- Name the sexual and reproductive health risk factors affecting vulnerable adolescents and those living with HIV.
- Choose and apply effective ways to address challenges that arise when providing health services to adolescents; and
- Utilize the new skills in values clarification and emotional intelligence to provide quality services to adolescents.

5.1.4 In-School Youths initiatives

The National Family Planning Board-Sexual and Reproductive Health Agency's Hold On, Hold off programme addresses issues of self-awareness, decision making and abstinence as well as other sexual reproductive health issues. The programme curriculum was designed to strengthen and support the Guidance and Health and Family Life Education (HFLE) curriculum. The intervention targets grade 7-9 students and lasts for a period of five months.

For the reporting period 2016 the intervention was implemented in two schools (Swallowfield Primary and Junior High School and Vauxhall High School). Interactions were had with approximately 1,050 students ages 13-16 years. The results of pre and post-test indicated an increase in students' knowledge of HIV/AIDS and STI'S.

The Family Planning Association (FAMPLAN) was instrumental in providing comprehensive sex education in schools and communities as well as peer educators trainings, peer counselling and psychosexual counselling. This was delivered by top-notch professional and trained psychologist.

Challenges:

Sustaining programme results: After the interventions are completed in the various schools currently there is no system in place to maintain the adjustments in the attitude, practices and behaviour of the students.

Way Forward

Inter-sectorial collaboration: Strengthening students' existing support systems by sustaining messages covered in the intervention through the supply of SRH materials and education to stakeholders and community members.

5.1.5 Out of School Youths

The standard package available for the out of school youth population includes offering free HIV and Syphilis screens, risk reduction assessments and reduction conversations, condom demonstrations, STI/HIV/AIDS conversations, condom demonstrations and distribution. The total number of persons ages 15-19 years reached and tested island wide are 21,368 and 2,337 respectively. Unfortunately, there are no funds available to conduct empowerment workshops and training sessions for individuals from this population.

5.1.6 HFLE Revision

In 2016 the MOE commenced revision of the HFLE curriculum at both the primary and secondary level. Revisions to the Sexuality and Sexual Health theme for grades 1-9 were completed and reviewed by key stakeholders for feedback and recommendations. The revision of the Appropriate Eating and Fitness theme was also completed and submitted to MoH for review and feedback, while Managing the Environment was 50% completed. Revision of Self and

Interpersonal Relationships theme commenced but was only 50% completed at the primary level.

As a part of the rollout of the National Standards Curriculum, teachers from grades 1 and 4 were trained in life skills-based HFLE lessons planning and delivery. A total of 3558 primary level teachers were trained at the national level, while over 1278 primary and secondary level teachers participated in school-based training. 34 HFLE Teachers and College Lecturers were also trained as HFLE Master Trainers; 19 HFLE Teachers and Master Trainers were trained in alternative assessment in HFLE and are currently field-testing 26 HFLE classroom assessment tools to measure learning outcomes of HFLE; 36 teachers from the primary level participated in training on sexual abuse and 166 students participated in an empowerment exercise related to this activity.

154 HFLE teachers and guidance counsellors were trained in gender-based violence as part of Safer Sex Week activities. The Ministry of Education, Youth and Information also commenced the development of a Sexuality Education Training Programme for HFLE Teachers. The draft document has been submitted for review and field-testing is expected in 2017. To support this activity, approximately 68 HFLE teachers and guidance counsellors also participated in a sexuality education capacity building workshop in December 2016.

6.0 Commitment 6: Ensure that 75% of people living with, at risk of and affected by HIV benefit from HIV-sensitive social protection by 2020.

6.1 Skills Training through RHA

The NFPB-SRHA engaged in interventions to address the social welfare and needs of the MSM community through offering skills training. Through this initiative the Southern Regional Health Authority (SRHA) has assisted 14 individuals with obtaining CSEC subjects and completing college courses. The NFPB-SRHA has helped 34 individuals obtain certification in makeup artistry, bartending and graphic design.

6.2 Social Protection Programmes

6.2.1 Social Protection for the Homeless – NCDA

Overview

The National Council on Drug Abuse's mandate to reach and test homeless key populations have provided homeless men who have sex with men, transgender and sex workers with several services (nutritional support and other key services). Nutritional support is provided through regular distribution of canned foods, rice and crackers. This is bolstered by hygiene items such as toothpaste, toothbrush soap, washrag, sanitary napkins, deodorant, nail polish body spray and body wash. Clothing is also provided which was donated by the Salvation Army. Other key services provided included counselling, linkage to residential drug treatment, transportation to treatment, reintegration to family, linkage to mental health treatment in partnership with the Cornwall Regional Hospital and linkage to care in partnership by the Comprehensive, Maxfield and Windward Road Health Centres. In addition to these services, members of the homeless population were treated to a Health Fair in Montego Bay, St. James where the following services were provided:

- Blood pressure/ Blood glucose check- provided by St Christopher's school of Nursing and Central Academy School of Nursing

- Manicure, Pedicure, facial massage- provided by Community School of Cosmetology
- Training opportunities- provided by HEART Trust
- Condom and lubricant demonstrations- provided by Stakeholders
- General Medical Information- provided by Western Regional Health Authority
- Mental Health Information-provided by Western Regional Health Authority
- Substance Abuse Services- provided by NCDA
- HIV/Syphilis testing- provided by Western region Health Authority
- Barber services- provided by Staff, Volunteers
- Venue was paid for by Amahoro Ministry

Certified Skills Training

The National Council on Drug Abuse facilitated the registration of eight MSM for remedial classes at the Jamaica Foundation for Lifelong Learning (JFLL) while three registered for practical nursing at St. Christopher's School of Nursing. Since both programmes are one year and eighteen months in length, respectively, their true impact will not be known until 2017 and 2018, respectively.

6.2.2 MOH Social Protection initiatives

The Whole school programme places PLHIV students in school with the Mustard Seed Communities, parents and guardians who need support in placing students in educational institutions.

6.2.3 MLSS Social Protection (PIOJ)

The Ministry of Labour & Social Security (MLSS) provides social assistance to PLHIV through some of its social programmes; albeit in a qualitative manner. The nature of the assistance doesn't lend itself to quantify the number of PLHIV that benefits directly from these programmes as there is no requirement for a beneficiary or potential beneficiary to disclose their HIV status. The MLSS through its Programme of Advancement Through Health and Education

(PATH) provides social protection to the most needy and vulnerable in Jamaica. It is a conditional cash transfer programme that uses a Proxy Means Test to assess if applicants satisfy eligibility criteria. The beneficiaries are in five broad categories namely children, the elderly 60 years and over not in receipt of a pension, persons with disabilities, pregnant and lactating women and poor adults 18-59 years old. The registered beneficiaries are required to satisfy specified criteria for continual receipt of benefits. Beneficiaries of health grants are required to register in a Government Health Centre and maintain a prescribed schedule of visits based on their age and benefit category. However, it should be noted that although there is no specific intervention that targets PLHIV, persons from this category who satisfy the eligibility criterion will benefit from this social assistance. The PATH programme also has a module known as “The Steps to Work Component” where entrepreneurial grants are given to beneficiaries that satisfy and eligibility criteria to undertake entrepreneurial activities that will lead to independence and self-sustenance.

The MLSS also provide Rehabilitation Grants which are available for persons who in the past have exhibited their self-supporting potential but who are experiencing circumstances that prevent them from providing for their basic needs or that of their families. Applicants should also be able to operate a project that is viable or which will enable them to enter suitable employment.

7.0 *Commitment 7: Ensure that at least 30% of all service delivery is community-led by 2020.*

The Civil Society’s role in reaching, testing and retaining persons living with HIV and key populations into services in Jamaica is a noticeable accomplishment. This section outlines the contributions of these partners to the national response.

7.1 Jamaica AIDS Support for Life (JASL)

Jamaica AIDS Support for Life (JASL) is the oldest and largest AIDS-focused, human rights, non-governmental organisation and has been in existence since 1991. JASL has three (3) Chapters: Kingston, Ocho Rios and Montego Bay; and its headquarters is located in Kingston.

JASL is dedicated to preserving the dignity and rights of persons living with HIV and AIDS and to help in the fight against the spread of HIV and AIDS by providing education and other interventions – to promote changes in attitudes and behaviour and empower persons to respond positively to the challenges associated with being vulnerable to infection in Jamaica.

The organisation does not discriminate against persons because of colour, race, disability, gender, class, sexual orientation, age, or religious beliefs. The JASL focus groups are made of those individuals, who because of social status, sexual orientation or gender, may be especially vulnerable. The organisation has built a reputation for successfully working with people living with HIV (PLHIV) and high-risk groups including: men who have sex with men (MSM), sex workers (SW), the hearing impaired (HI), orphaned and vulnerable children (OVC) and Transgender persons (and the LGBT community generally).

PROGRAMMES & SERVICES:

HIV and AIDS Education, Prevention & Linkage to Care services

Among the prevention services offered are outreach interventions, support groups and life skills sessions.

Outreach interventions are comprised of both group interventions and one-to-one peer education sessions with key populations at high risk. These sessions are designed to provide information about HIV and risk reduction counselling, offer sexual and reproductive health commodities and IEC materials, encourage HIV testing and provide referrals to the requisite services. Outreach sessions are conducted in a range of locations including private residences, nightclubs, parties, parks, street and community-based sites.

Jamaica AIDS Support for Life (JASL) provides a safe space and an opportunity to socialize and dialogue around issues affecting the gay, lesbian, bisexual and transgender community. **Life Skills Sessions** are peer-led and popular discussion topics include: sexuality, relationships, advocacy, self-esteem and HIV prevention. Life Skills meetings are held for all key population groups: members of the LGBT community and PLHIV.

Under the prevention component, **Support Group Meetings** provide an opportunity for members of the Sex Workers (SW) and men who have sex with men (MSM) community to discuss issues relating to their sexual health and well-being in a non-judgmental and confidential space.

JASL has also been integral in the development of Information and Educational Communication (IEC) materials and continues to do research on the epidemic in Jamaica with a focus to ending the epidemic.

Treatment, Care and Support

Treatment, Care and Support services include clinical sessions with a doctor and a nurse, adherence counselling, general counselling, individual sessions with a psychologist, CD4 testing, STI testing, pap smears, Positive Health Dignity and Prevention (PHDP) workshops, as well as PLHIV-MSM, PLHIV-SW and PLHIV support groups.

These support groups were established to provide a supportive environment for people living with HIV (PLHIV) to share their experiences and challenges, as well as to receive information, skills and commodities that will support them in maintaining a healthy lifestyle.

The PHDP workshops encompasses Prevention with Positives, to address the behavioural and socio-cultural factors, in order to reduce the risk of HIV transmission to others; as well as a broader focus on supporting PLHIV to maintain their physical health and psychological well-being. Several issues discussed in the workshops include antiretroviral therapy and adherence, information on CD4 counts, disclosure, addressing stigma and discrimination and the impact of HIV on lifestyle and relationships. The PHDP workshops also engage PLHIV in building their advocacy and leadership skills.

Efficiency and effectiveness of the referral system for patients

Referrals to specialised, diagnostic and other HIV-related services are done to JASL as well as to other partners/stakeholders. Initial and more detailed assessments are conducted to ensure beneficiaries are connected to the most appropriate services. JASL's peer programmes account for the majority of referrals made.

The organisation does not possess a formal, documented referral system with a database of available HIV and HIV-related services offered by public and private agencies for coordinating client connections. Connections to services are made based on the individual knowledge of present and past staff.

To ensure that clients are directly linked to services offered by JASL and/or other agencies, efforts are made for accompaniment or compensation where possible. In circumstances where the aforementioned are not possible, it may be difficult to account for connections made to JASL or other agencies.

Establishing an Enabling Environment

The JASL has engaged in various advocacy initiatives including Gender Equality and Human Rights trainings, as well as involvement in several groups such as the Country Coordinating Mechanism (CCM) for the Global Fund, PANCAP, CVC, the Civil Society Forum, and the MARPs Technical Working Group. The organization has also been an advocate for the provision of sexual and reproductive health services to persons with disabilities and in this regard has specifically held public events to highlight the needs of the hearing-impaired and share the success of the programme that JASL offers to this community. In addition, JASL has engaged

with the media to speak about issues affecting most at-risk populations as well as the broader national HIV response.

The JASL has also sought to address the factors that increase client’s vulnerability to HIV and as a result through donor support it has provided entrepreneurial workshops to build skills and capacity to establish businesses, as well as provided income-generating grants to support these initiatives. Additionally, the organization has been able to offer educational grants to MSM and SW clients who express interest in pursuing vocational training or to enrol in remedial classes.

Jamaica AIDS Support for Live – Best Practice

NISP Target (More than 1 target may apply)	Optional
National Strategic Plan programme area Example: Prevention	Prevention Treatment Care and Support
Name of organization	Jamaica AIDS Support For Life
Name of Programme/Project	Peer Navigation towards Linkage & Retention in Care
Background (limit - 150 words) a) Brief problem statement	According to the 2012-2017 National HIV/AIDS Strategic Plan, “despite the scale up of interventions to reach key populations, it is estimated that only 30% of these populations are being reached.” Additionally, <i>“Persons living with HIV (PLHIV) and in particular MSM/TG in Jamaica are not accessing HIV treatment services due to limited understanding of the virus, an unclear treatment process and high levels stigma in care facilities resulting in low levels of linkage to Care and/or Retention in Care”</i> .
b) Relevance	Understandably, persons who are recently diagnosed with HIV are frightened, confused or fear accessing services due to (possible and perceived) stigma because of their HIV status, criminalized activities such as sex work or their sexual orientation. This is also compounded by the process associated with treatment of the HIV - everything from the blood work associated with the confirmation, CD4 and viral load testing to adherence. Jamaica AIDS Support adopts a strong community led approach in two ways (i) utilizing peer navigators to reach peers at risk of contracting HIV through public outreach and testing and (ii) peer navigation approach along the continuum of care – from the initial

<p>c) Include project objectives and methodology.</p> <p>d) <i>Was ethical</i></p>	<p>diagnoses to achieving viral suppression. These approaches bear relevance to Jamaica’s National Development Plan and Medium-Term Socio-Economic Policy Framework in terms of enabling a healthy and stable population, within the context of the protection of human capital.</p> <p>Peer navigation is the method of navigating a person through their course of treatment from testing through to viral suppression. The JASL also ensures that its peer navigation model is inclusive of effective social support as navigators provide moral support and motivation to patients. Notably, JASL is the only community led organization in the Caribbean that utilizes peer navigation along the entire continuum of care - <i>other community groups utilize peer navigators for reach and test</i>. To this end, the best practice model focuses on this approach.</p> <p>What increases the effectiveness of JASL’s peer navigation model is that it features a strong composition of PLHIV, MSM and TG peer navigators to increase testing, treatment, and retention outcomes for PLHIV and other higher risk populations. Evidence of this is the fact that members from the key populations permeates all levels of the JASL team where 60% of all staff and board members identify as gay, 20% bisexual, 10% lesbian, 20% trans-women, 10% trans-men and 80% HIV positive.</p> <p>Methodology</p> <p>In providing oversight of peer links, navigators work closely with the Targeted Outreach Officers to map PLHIV and key populations and set targets for outreach. Tied to this is the coordination of targeted outreach activities, also noting that persons can be found positive through “walk-ins”.</p> <p>However, what makes JASL peer navigation model unique is that once persons are found reactive, they are immediately assigned to a navigator (or they can choose one). The Navigator guides them through the different stages and supports them through the setting and follow-up of appointments with the Psychologist, Nutritionist, Adherence Counsellor or Clinic as needed. It provides a priority access of sorts. This increases the comprehensive care and support programme being offered where the navigator is equipped to advise on treatment literacy, nutrition, behaviour change and general adherence support – all of this within the</p>
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<p><i>considerations observed?</i> The programme follows established norms of social and professional conduct and does no harm. Also importantly in the context of scaling up, the programme does not draw resources away from other (successful) health care projects or service provision.</p>	<p>context of the Peer Navigator having adequate working relationship with the various personnel along the continuum of care to improve the health and social outcomes of the client.</p> <p>The JASL strongly emphasizes virtue and principle ethical considerations in its peer navigation model. For example, there are strict codes of conduct regarding issues of patient privacy and confidentiality. These are upheld, with full consideration to the respect for human rights and non-maleficence at all times.</p>
<p>Timeline (start to end)</p>	<p>January 2016 – December 31, 2016</p>
<p>Funder</p>	<p>USAID (MOH) & LINKAGES</p>
<p>Implementing partners</p>	
<p>Beneficiary population List all that apply</p>	<p>MSM TG SWs PLHIV</p>
<p>Inputs (financial, human resource, etc)</p>	<p>18 Navigators (3 chapters /sites) Training Materials</p>
<p>Results</p>	<p>161 persons were found reactive to HIV in 2016</p> <ul style="list-style-type: none"> • 80 of which were MSM <p>121 were Linked to care at JASL Sites</p> <p>JASL is currently varying what number of the remaining 40 are accessing services elsewhere</p>
<p>Impact if evaluated</p> <p><i>Effective:</i> evaluated success of programme in producing the desired outcome and its impact on HIV (evaluation need not be external and need not be quantitative but ideally it is built in to the programme, it is regular and ongoing; the views of those addressed by the programme are especially important that is do the people addressed think that the programme has done</p>	<p>Was the programme/project effective? Owing to the encouraging number of persons virally suppressed during the period - 49% of all PLHIV enrolled at JASL received at least one instance of viral suppression during 2016, JASL is lead to believe that the process is effective. However, a formal impact evaluation is currently underway</p>

<p>some good? External 'scientific' evaluation is valuable although often not possible).</p> <p><i>Cost efficient:</i> relationship between cost and results and seeks to record good results achieved at low (unit) cost.</p>	
<p>Sustainability Ability of the programme to continue after external support has ended or importantly after the founder/leader has left. Ability of the programme to continue to develop in the face of changing epidemic.</p>	<p>Navigation has been built into JASL's suite of services. Sustainability will be achieved through the institutionalization of the functions associated with navigation making it a standard part of the programme offering even beyond the funding period.</p> <p>Navigation closely shadows the role of the Case Manager and will be merge into that function should that situation arise.</p> <p>It is important to note that relation building within the community and among peers significantly increases the sustainability of results as beneficiaries and clients have owned the process. Notably, by empowering the community with behaviour change messages and concept of support group approaches, some clients would have also formed their own support groups during the process.</p> <p>The JASL's <i>modus operandi</i>, continues to contribute to the Sustainable Development Goal numbers 3 and 5; namely: Ensure healthy lives and promote well-being for all at all ages, particularly in regards to HIV/AIDS; and Achieve gender equality and empower all women and girls.</p>
<p>Lessons learned</p>	<p>The primary lessons were that persons are not necessarily unwilling to access care. They are sometimes just unaware of the process and have limited support.</p> <p>Comprehensive Case management is an effective strategy for Linkage and Retention in Care of PLHIV. The client services tracker, promptly identified gaps in service access pattern and allow for intervention from the Peer navigators and /or case managers.</p> <p>Peer support remains critical to the linkage to care of Key populations</p>

Challenges	The biggest challenge was that not all MSM wanted to be navigated by their peers. The community is relative small with several intersections and most persons are either friends or friends of friends and that creates its own set of challenges around who they may or may not want to know. This is also the very reason why navigation works and so it cancels out itself
What makes this a best practice? a) Evidence informed; b) Innovative; c) Effective d) What was done outside of the norms of routine programmes?	Building trust with the PLHIV community and reaching high risk “hidden populations” has been a challenge within the health services [succinctly state in what way]. Additionally, as stated above, JASL is the only community-based organization in the Caribbean that has been utilizing peer navigators along the continuum of care. Other agencies have utilized peer navigation for reach and test. When a system of trust is built, it increases accuracy of information being provided, and therefore, programme planning is more evidence-informed.
Name and position of person authorizing best practice report	Xavier Biggs Monitoring & Evaluation Manager

7.2 The Ashe Company

The Ashe Company is a non-governmental, theatre arts and edutainment company in the English speaking Caribbean. The entity's contribution to the HIV response is packaged around empowerment FIRST at all levels of the HIV continuum. Their preferred mode of delivery is edutainment through the use of various art forms to creatively coin and deliver HIV prevention, treatment and care messages. The Ashe Company, while traditionally focused on youth, has embarked on the reach, empower and testing of men who have sex with men (MSM) and transgender (TG) in recent times. In Jamaica, the Ashe Company's model can be considered an effective strategy for reaching key population members because of its unique access to MSM. As the Ashe Company is well known for its proficiency and creativity in the arts, MSM with similar interests will have a natural inclination to seek health and empowerment services at the entity. The Ashe Company is a significant partner in the HIV response providing HIV and Syphilis testing, linkage to care and most importantly for them, empowerment through edutainment.

ASHE– Best Practice

NISP Target (More than 1 target may apply)	Optional
National Strategic Plan programme area Example: Prevention	Prevention
Name of organization	The Ashe Company
Name of Programme/Project	Attractor Factor & Spectacular 6
Background (limit - 150 words) e) Brief problem statement f) Relevance? g) Include project objectives and methodology. h) <i>Was ethical considerations observed?</i> The programme follows established norms of social and professional conduct and does no harm. Also importantly in the context of scaling up, the programme does not draw resources away from other (successful) health care projects or service provision.	<p>Despite the gains achieved in the fight against the HIV/AIDS epidemic, the Ashe Company recognized that the traditional method of saturating the key populations with information on why it was important to practice healthy sexual behaviour and providing the necessary resources to further promote these positive behaviours through preventative methods (free condom distribution, free VCT/PITC) was still not very effective as there still remained a high rate of HIV transmission among MSM population. As such, the decision was made to resume long term empowerment work that is more likely to yield positive results and create behaviour change by focusing not on condom use, treatment adherence and low risk behaviours, but giving attention to the concepts that would cause an individual to be more likely to demonstrate these behaviours.</p> <p>Having had prior success with using edutainment as a tool for personal development, the Attractor Factor program was rolled out to the MSM & TG community as a means of having individuals explore their personal values and recognize how these values contribute to their behaviours and life styles. The program also focused on providing alternate ways of thinking and behaving as a means of helping participants to develop self-love, self-acceptance, and self-care; components which would naturally lead to individuals taking the actions that would result in decreasing their risk and minimizing the transmission of HIV/AIDS within the population.</p> <p>The objective of the project was to increase the self-efficacy of the participants and empower them to make positive lifestyle choices. The program was undertaken over a 12-15 weeks period in which participants were first introduced to the program and the different tools and rules that would be</p>

	<p>applied throughout the process. In this initial three day workshop they became familiar with their facilitators and fellow cohort mates, explored the difference between change and transformation, explored the rules of empowerment and were made to recognize that they were creating a safe, non-judgmental atmosphere for creating the person they wanted to be. Thereafter they would meet once per week and would explore topics such as labels, self-esteem, stigma and discrimination, life goals, etc. The methodology employed was the Ashe E.I.C. methodology that utilized the arts by trained peer educators to appropriately explore and respond to the challenges and questions raised by the participants as they explored the G.P.A. Empowerment System which is a tool guide that explores individual empowerment and carries an individual through the transformative process of becoming an empowered being. At the end of this period participants were given an opportunity to showcase the lessons learned as well as “pay it forward” by referring and nominating their peers to be a part of subsequent Cohorts.</p> <p>Subsequent to the two cohorts that experienced the programme, many individuals expressed interest in continuing their growth and as such were focused on seeking career opportunities. One challenge with that was the fact that many were high school drop outs or had underachieved in the secondary education system. This then opened the door for the need to now provide skills training. This led to the development of the Spectacular Six (S6) skills building series. This aspect of the programme involved providing training in six different skill areas and building the capacity of key population members in these areas; Performing Arts, Digital & Video Photography, Studio & Sound Engineering, Entrepreneurship, Interior Décor & Design, Social Media Marketing.</p>
Timeline (start to end)	August 2016-December 2016
Funder	USIAD & Global Fund
Implementing partners	The Ashe Company
Beneficiary population List all that apply	Men who have sex with men (MSM), Transgender Community
Inputs (financial, human resource, etc)	The project was executed by a Project Manager who was responsible for the direct implementation and monitoring and evaluation of the project. The Peer Navigators assisted

	with the oversight and recruiting of participants. Facilitator’s for the different skills areas was contracted using professionals in each area.
Results	36 persons completed the Attractor Factor 2.0 program for which they gained a certificate. The S6 program resulted in a total of 42 individuals gaining certificates of completion for that programme.
Impact if evaluated <i>Effective:</i> evaluated success of programme in producing the desired outcome and its impact on HIV (evaluation need not be external and need not be quantitative but ideally it is built in to the programme, it is regular and ongoing; the views of those addressed by the programme are especially important that is do the people addressed think that the programme has done some good? External ‘scientific’ evaluation is valuable although often not possible). <i>Cost efficient:</i> relationship between cost and results and seeks to record good results achieved at low (unit) cost.	<p>Participants have reported that the A.F. sessions had been very encouraging as it had allowed them to recognize the things that affected them and to work out some of these issues that created negative experiences. One participant expressed that the sessions had allowed him to recognize that he is the one that is in control of himself and his response to others and so he has learned how to better control himself and not “flare up” at everything others say especially when he knows it is not true. Overall participants expressed how the programme has changed them, such as by helping them to value themselves and recognize that they need to make the step to do the things they want and not wait on their relationships to provide for them.</p> <p>The S6 phase of the project saw approximately 60 participants attending the series each week. This led to capacity development in different individuals which also resulted in two members of the training being taken on by Ashe as a technical engineer (through the studio and sound engineering course) and another as a peer link who assists with social media marketing (through participation in the Digital Media and Photography and Social Media Marketing courses). Participants noted that the sessions were educational and they learned a lot. One individual highlighted that he was appreciative of the course as he was provided with information and practical ways to earn an income which based on his financial status he would not have been able to do. Two members of the entrepreneur class noted that while they had small self-employed ventures the course assisted them with recognizing and planning effective ways that they were able to apply to their business and see present growth.</p>
Sustainability Ability of the programme to continue after external support has ended or importantly after the	The incorporation of the S6 programme after careful thought decided to include members of the general population at a cost. This was also as means of strategically building our own brand as a skills building hub. This has given rise to the Ashe Edutainment Institute which we anticipate providing similar skills training at a cost. This will

<p>founder/leader has left. Ability of the programme to continue to develop in the face of changing epidemic.</p>	<p>allow for financial resources to support the life of the programme and its longevity even after funding sources leave.</p> <p>The S6 programme has also restarted through the 2017 Global Fund support.</p>
<p>Lessons learned</p>	<ul style="list-style-type: none"> • The programmes reinforced the fact that edutainment is an effective means of reaching the populations and empowerment as the focus of our message results in better relationships with the population and lasting change. • It is important that sometime in the near future the training be certified. Many of the participants were excited by gaining a certificate and having this be a HEART Trust qualified programme would be even more beneficial to the participants as it can be used to gain employment even outside of the scope of organizations that work with key populations and have a knowledge of the work that we do. • Liaising with partner organizations to recommend participants particularly for the skills building aspect of the training was an effective strategy. This resulted in persons travelling from different parts of the island (Clarendon, Portland, and Manchester) to be a part of the programme. This may also mean that in future we may need to consider the possibility of offering these programmes outside of our own geographic location of Metropolitan Kingston. • Being particularly mindful of when the trainings are scheduled will affect the turnout and even the consistency of attendance with the population.
<p>Challenges</p>	<ul style="list-style-type: none"> • Finding a convenient time for all participants was difficult as such the weekend was chosen as the best time. • Despite having over 120 persons registering for the S6 programme initially, we only had approximately 80 students who attended overall. Even in this number there was a high level of inconsistent turnout. This may have been as a result of the fact that this course was close to the end of the year thus the holiday period which usually results in poor turnout of the population. Additionally the first 2 weeks was affected by severe rain conditions and that may have also affected the programme.
<p>What makes this a best</p>	<p>The Attractor Factor program has been proven to be</p>

<p>practice?</p> <p>e) Evidence informed; f) Innovative; g) Effective h) What was done outside of the norms of routine programmes?</p>	<p>a successful model as it was the result of a previous project. The use of peers as the recruiters and in several instances as the facilitators for the programme meant the attraction of the program to the young key population was established and was successful as having each successive cohort invite and recommend their own peers meant new participants were already aware of the changes that the programme could bring and were desirous of gaining the same for themselves.</p> <ul style="list-style-type: none"> • The effectiveness of the programme is also seen through the number of persons who after participation reported better interpersonal relationships, there was also several who had gained employment (even outside of those that joined Ashe). • This is a one of a kind programme as it is strictly crafted using edutainment and also has the entire focus on the individual as a whole as opposed to dealing with only their sexuality as is the case with most other projects in the strategic programme against HIV/AIDS. The fact that we also mixed the personal development aspects with providing practical skills that were aligned with their interest also make this an innovative programme.
<p>Name and position of person authorizing best practice report</p>	<p>Conroy B Wilson, Executive Director</p>

7.3 Children of Faith

The organization Children of Faith provides prevention services mainly to adolescents and children living with HIV. They also support ALHIV in receiving treatment, counselling and education. For the period January to December 2016 the organization has provided the following services:

- VCT with 210 CSW.
- Psychological assessment and at least one (1) hour psychotherapy with 37 ALHIV
- Attendance at HEART - 5 ALHIV are acquiring skills
- IGA provided for 13 Families/ALHIV infected and affected and one (1) TG

- Paid school fees and receipt of school uniforms, shoes, text-books, and other items for 46 orphans affected and infected by AIDS
- Receipt of weekly groceries by 37 ALHIV.

7.4 Jamaica Network of Seropositives (JN+)

The Jamaican Network of Seropositives (JN+) is a national non-profit advocacy organization established in 1997 to provide peer support and support groups for Persons Living with HIV (PLHIV) and their affected families in Jamaica. At present JN+ provides:

- Training/Capacity Building/Self Development,
- Referrals for services
- Access to Redress
- Peer-to-Peer Support

JN+ collaborates locally, regionally and globally with other networks, stakeholders and partners in the HIV response. It is also the recognized voice of PLHIV affiliated to the Caribbean Regional Network of Persons Living with HIV and AIDS (CRN+).

7.5 Children First

Overview

Children First is a non-governmental organization in Jamaica that works predominately with adolescents using the participatory approaches to empower adolescents to become actively involved in decision making. Generally, Children First's unique niche manifests in skills training in the areas of cosmetology, barbering and life skills. The work of the entity in Jamaica's HIV response comes in the form of HIV and Syphilis testing, linkage to care and skills building and skills training. Also, Children First utilizes various forms of art such as singing and dancing to capture the attention of adolescents as a behaviour change communication tool.

During 2016, Children First also conducted a Life Skills Programme for Adolescents dubbed “Kreatively Kool Kids for Life Programme”, skills training, treatment sessions and interventions with juveniles.

Kreatively Kool Kids 4 Life

This programme was developed in an attempt to create a safe space for children 9-14 years old living in vulnerable communities. Through this programme, the children were engaged in workshop sessions through the use of edutainment and other hands on activities that deliver age-appropriate information about life skills under various themes. Over fifty (50) children benefitted from the programme.

Skills Training Sessions

A total of 23 persons completed the cosmetology programme while 13 persons completed the barbering programme in 2016. Also, 12 MSM completed a series of Makeup Skills Training. The aim of these training sessions was to provide interested individuals with Make-up training lessons by empowering and equipping participants with learning the theory and the skill that applies to Make-up Artistry. These training sessions were not only limited to make-up training, but also included life skills and practices. Participants were also exposed to sex education where they were counselled on safe sex practices, proper condom use and condom negotiation. The participants were also counselled on HIV/AIDS prevention, the importance of linkage to care and treatment and drug resistant.

Treatment Sessions

During the third quarter of 2016 the members of the Case Management Department conducted a series of treatment sessions. The main objective of these sessions was to provide members of the Key Population who are living with HIV with the necessary information about the different types of HIV medication, the different stages of HIV, adherence to the drugs, and the importance of continuing the medication. These sessions also provided information as it relates to the importance on condom use and other life skills. Approximately 25 persons were impacted through these sessions.

Interventions with Juveniles

During the period of 2016, the Children First team conducted a series of interventions within the juvenile correctional facilities located in St. Ann and Kingston & St. Andrew. The main focus of these interventions was to provide the remandees with practical skills such as Art & Craft, Cosmetology and Barbering skills. This programme was funded by UNICEF.

8.0 Commitment 8: *Ensure that HIV investments increase to US\$26 billion by 2020, including a quarter for HIV prevention and 6% for social enablers*

During 2016, the Ministry of Health continued implementation of resource tracking for the AIDS response. The Ministry, with technical support from the UNJT on AIDS conducted the third resource tracking activity utilizing the National AIDS Spending Assessment (NASA) tool. The assessment employed standardized methods, definitions and accounting rules to track HIV and AIDS expenditure across financing source, financing agent, service provider, production factor, services provided and beneficiary population for the periods April 2013 to March 2014 and April 2014 to March 2015.

The results showed that Jamaica still relies heavily on international donor funds for its HIV response. However, when compared to previous resource tracking exercises over the years the Government of Jamaica (GoJ) expenditure has increased both in nominal and real value terms; while the total AIDS expenditure has decreased in real terms over the years. The main funding sources for the two fiscal periods were the Global Fund (GF), Government of Jamaica (GoJ), and the Government of the United States, through PEPFAR, Household Funds (HH), and the UN Joint Team on AIDS.

The total expenditure for the fiscal years 2013-2014 and 2014-2015 were \$12,643,431.58USD and \$15,073,726USD, respectively. The decrease in expenditure for the 2013/2014 period compared to the 2012/2013, which was approximately 20 million USD, can be attributed to the winding down of the Global Fund Round 7 Grant which came to an end June 2013 and the employment of the Transitional Funds from the GF which began in August 2013.

The service providers implement the activities for the prevention and treatment of HIV/AIDS. They range from government institutions such as Regional Health Authorities, Ministry of Education, NGOs and hospitals. Service providers influence the resources expended as they have intimate knowledge and understanding of beneficiary populations and the interventions needed to mitigate the impact of HIV and AIDS.

Analysis of the data showed that most of the funds expended for services provided were done by the public sector, which includes the regional health authorities (RHAs) and other Ministries such as the Ministry of Education. Non-profit organizations or civil society organizations provided services to the tune of approximately \$2.92M USD and \$2.40M USD for 2013/14 and 2014/15 respectively. This represents 23% and 15.9% respectively of expenditure for 2013/14 and 2014/15. Private for-profit provided services represented approximately 11% and 10% of expenditure respectively for 2013/14 and 2014/15. The services provided were mainly focused on prevention packages and treatment and care services.

Overall, Jamaica met the global “quarter expenditure for prevention target” both in total and in public expenditure (see table 7). Notably, the GoJ accounts for the majority of expenditure on treatment and care, a key point as the country engages in discussions on sustainability of the AIDS response.

See Tables 7 and 8 below for funding expenditure by categories and Annex 2 for the Funding Matrix.

Table 7: Expenditure by Funding Source

Category	2013/14 USD	%	2014/15	%
Public	4221876	33.3	4093248	27.2
Private	1490363	11.8	1645020	10.9
International	6913285	54.7	9335457	61.9
Total	12641382	100	15073726	100

Table 8: Expenditure by AIDS Spending Category

	2013/14		2014/15	
	Exp.	%	Exp.	%
PREVENTION	5102575	40.4	5749382	38.1
Treatment & Care	2182764	17.3	2575778	17.1
PLANNING, COORDINATION AND PROGRAMME MANAGEMENT	4419034	35	5488822	36.4
TRAINING	180158.1	1.4	436267.8	2.9
SOCIAL PROTECTION	9804.09	0.08	7992.81	0.05
ADVOCACY	745664.2	5.9	780104.4	5.2
RESEARCH	1383.52	0.01	35378.75	0.2
Total	12641382	100	15073726	100

Assessment of AIDS expenditure would indicate that Jamaica has sub-optimal expenditure in social protection services, however integrated in treatment and care programmes are social services specific and targeted towards PLHIV. Treatment and care account for the majority of local public expenditure. Additionally, social programmes for the general population also afford expenditure on HIV, however due to reporting processes it is difficult to capture these expenditures.

As discussions on sustainability of the AIDS response advance, government may want to explore expanding funding sources beyond the main ones mentioned above. Also of importance is the need for civil society to explore new social enterprises for sustainability. The transition preparedness assessment recommended that the response explored among other things, an environment for social contracting for civil society.

9.0 Commitment 9: Empower people living with, at risk of and affected by HIV to know their rights and to access justice and legal services to prevent and challenge violations of human rights

In its efforts to empower people living with, at risk of and affected by HIV to know their rights and to access justice and legal services, to prevent and challenge violations of human rights the national response sought to undertake a variety of initiatives in 2016 which are outlined and discussed below.

9.1 Towards the Creation of a Comprehensive Redress Framework

Background/Rationale

In the absence of general anti-discrimination legislation in Jamaica and the recognition of the deleterious effects of stigma and discrimination (S&D) on the uptake of HIV prevention, treatment and care services by PLHIV and other key populations, the national SRH and HIV response in 2016 continued its relentless efforts towards ensuring the provision of redress in instances of HIV-related discrimination, human rights violations and gender-based violence. Primarily, efforts were centred on strengthening the foundation laid by the National HIV-related Discrimination Reporting and Redress System (NHDRRS) by commencing in 2016 a three-year consultative process involving a cross-section of multi-sector partners to develop a comprehensive redress framework.

Achievements

In 2016 the EEHR component of the national SRH and HIV response convened a total of four (4) redress consultations with representatives of key stakeholder groupings with the overall aim of defining the mandate and governance structure of a comprehensive redress framework. It is recognised that the existing NHDRRS needs to be bolstered by the creation of memoranda of understanding (MOUs) and standard operating procedures (SOPs) that will allow all redress partners to communicate seamlessly in the execution of their commitment to the provision of redress services. In this regard, the series of redress consultations carried out in 2016 focused on:

- ❖ The creation of Information, Education and Communication (IEC) materials to increase awareness of available redress services and in the process drive demand for and increase uptake of these services. Chief among the IEC materials were (i) a directory of redress services which was finalised, (ii) the revision of the Complaint Intake Form used in the recording of potential redress cases and (iii) the development of a low-literacy poster promoting the services available through the NHDRRS.

- ❖ The development of communication strategies to be used in the promotion of all the entities currently providing redress services in Jamaica.

- ❖ Establishing the link between human rights and the provision of redress through the observance of Human Rights Day 2016 for which the Keynote address was delivered by Jamaica’s current Public Defender, Mrs. Arlene Harrison Henry. Along with the Ministry of Labour and Social Security (MLSS), the Ministry of Health (MOH) through its Complaint Management System and the Dispute Resolution Foundation (DRF), the Office of the Public Defender (OPD) is a redress partner earmarked to play a pivotal role in the proposed comprehensive redress framework.

Challenges

Resource constraints pose a major challenge to the development of the required promotional materials that will increase the visibility of the redress system and in the process, increase

demand and uptake for available redress services.



Participants in the Redress Consultation held on November 8, 2016

Way Forward

The redress consultations will continue in 2017 in the gradual progression towards the creation of a governance structure that will facilitate the seamless operation of both existing and new redress partners through the provision of clear policy guidelines in the form of MOUs and SOPs.

9.2 JN+-Led Interventions Facilitating Redress

National HIV-Related Discrimination Reporting and Redress System

Background

The effects of HIV are cross cutting, affecting every aspect of human life and are seen in every setting: at home, within the community, in educational institutions, at work sites, in health care facilities even in churches. HIV is therefore not just a health issue, but also a productivity and national development issue. HIV-related stigma and discrimination have hampered efforts to adequately address HIV in Jamaica and in fact, continues to be one of the key drivers of the epidemic. Many persons infected or affected by HIV face discrimination related to real or perceived HIV status and for some persons their very association with persons believed to be HIV positive has resulted in them facing discrimination as well. The **National HIV-related Discrimination Reporting and Redress System** (NHDRRS) was therefore established in 2007 to address this issue.

Historically, the system facilitated the collection of complaints of HIV-related discrimination and channelled them to appropriate entities for redress. However, in 2016 it was decided to expand the reach of the system to include complaints of gender-based violence.

Best Practices

A process of rebranding and refocusing of the NHDRRS commenced in 2016 to ensure greater efficiency and accountability. This process included:

- Changes in the governance structure of the NHDRRS to subsume it as a sub-committee of the Enabling Environment and Human Rights Technical Working Group (EEHRTWG) of the National Family Planning Board –Sexual and Reproductive Health Agency (NFPB-SRHA)
- The development of revised TORs for the Steering Committee and Case Review Panel
- Development of standard operating procedures to govern the management of cases to ensure each case is followed-up to closure.
- Hiring of two (2) additional Redress Officers to collect and monitor complaints. This brings the total complement of Redress Officers to three (3). Salaries for the Redress Officers and the hosting of the committee meetings are supported by the USAID.
- Participation in the Shared Civil Society Incident Database (SIDney). In 2016, JN+ entered into a partnership with the Caribbean Vulnerable Community Coalition (CVC), Jamaica AIDS Support for Life (JASL), and JFLAG to develop a shared electronic database for recording and monitoring incidents of discrimination, abuse and other human rights violations among vulnerable communities.
- Improving the capacity of Redress Officers through training in paralegal studies and motivational interviewing

Challenges

- The absence of anti-discrimination legislation limits the level of action that can be taken in some situations.
- Difficulties in managing the expectations of those who report as oftentimes the type of redress requested cannot be facilitated under the circumstances or in the absence of legislation prohibiting the discriminatory action.

- Limited reporting by affected persons due to lack of trust. Many fear that reporting may lead to involuntary disclosure, further abuse or that the alleged perpetrator will not be held accountable.

Way Forward

- Strengthen partnerships and relationships with agencies whose mandates allow them to provide/facilitate redress, take appropriate action to prevent discrimination and/ or to hold people accountable for their (in) actions.
- Utilise the data gathered through SIDney to monitor incidents of discrimination and facilitate advocacy.

9.3 Provision of Paralegal Training

Background

In an effort to reduce the structural barriers faced by PLHIV and other key populations, JN + has been working at interventions to empower those served by the organization. As part of that effort, through funding provided by the Global Fund, JN+ provided scholarships for 10 PLHIV and other key population representatives to pursue paralegal training. The first cohort began training in September 2016 and is slated to complete the programme by mid May 2017.

Best Practices

- A fair and transparent selection process was used to select candidates. The opportunity was made available to all stakeholders not just those affiliated with JN+. The scholarships were advertised widely among sector stakeholders and persons meeting the basic eligibility requirements were encouraged to apply. Short listing and final selections were determined by an independent panel (external to JN+ and including our international development partners)

- All awardees had to be affiliated with and endorsed by a CSO. They were also required to sign a commitment to utilize their newfound skills within the nominating organization or elsewhere in the sector
- The training is provided by an accredited training institution; and qualifications received at the end of the programme will be tenable at law firms island-wide and can be the basis of further legal training. Those who successfully complete the course will be certified Paralegals.

Challenges

- The need for greater commitment on the part of participants to ensure that the training opportunity is maximized.
- The need for support from nominating organizations to motivate awardees to persevere and apply themselves even under difficult circumstances

Way Forward

- More robust advertising of the scholarship to generate more interest and increase the pool of eligible applicants.
- Implement a comprehensive orientation and information exercise for all shortlisted candidates prior to making final selections to ensure that all persons who receive a scholarship are fully au fait with the requirements and are prepared to take on the challenge of higher education.
- Consistent monitoring and evaluation to ensure objectives are met

9.4 Advocacy Training

Background

Under the auspice of the Global Fund, the JN+ spearheaded a three-day advocacy training workshop with 16 members including staff and the Executives. The training was geared towards

empowering participants to become “agents of change” and help them to develop strategies to better advocate for the needs and concerns of PLHIV.

Best Practices

- Participatory approach to training allowed for hands on experience in developing advocacy strategies.
- Detailed knowledge transfer regarding laws, policies and guidelines that govern HIV and related issues.

Challenges

- Mobilizing PLHIV who are comfortable enough with their status to publicly discuss HIV and to participate in advocacy efforts.
- Identifying persons who are committed and willing serve

Way Forward

- On-going support to foster and hone advocacy skills among those trained.
- Providing opportunities for implementing activities in keeping with organizational objectives and advocacy plans.

9.5 MLSS–Advocacy/Public Education

9.5.1 JIS Features

The MLSS with support from the United States Agency for International Development (USAID), had entered into an agreement with the Jamaica Information Service to undertake a public education campaign that was aimed at increasing awareness of the National Workplace Policy on HIV and AIDS and increasing tolerance in the workplace and business sector. In order to achieve this the Jamaica Information Service produced radio and television features on the development of the National Workplace Policy on HIV and AIDS.

9.5.2 Presentation on the OSH Bill

Supported by staff of the NFPB-SRHA, the MLSS HIV Unit coordinated a presentation on the Occupational Safety and Health Bill to MLSS staff along with staff of the NFPB-SRHA. The Unit, along with officers of the OSH Department and the NFPB's EEHR Unit also participated in a capacity building exercise on the Policy Making Process and the Development of Cabinet Submissions.

9.5.3 Sensitization around the OSH Act

The HIV Unit was invited by the Ministry of Finance to present to One Hundred and Twenty (120) HR and IR practitioners in Ministries, Departments, Statutory Bodies, and Public Bodies/Agencies in 2016. The objectives of this workshop were to

1. Increase the awareness of the pending OSH Act.
2. Inform HR/IR practitioners of their roles and responsibilities in administering the ACT.
3. Inform HR/IR practitioners of the employees' rights under the ACT.
4. Inform and advise HR/IR practitioners on the process involved in seeking redress.
5. Adapting a rights based approach to managing HIV in the workplace by recognizing HIV as a workplace issue. Based on feedback from this group over the three (3) days, it is believed that we should capture this group again to build their capacity in interpreting and applying the National Workplace Policy on HIV and AIDS from a legal perspective.

9.6 Legal protections for key populations

9.6.1 Workplace Programme

Ministry of Labour and Social Security

In 2016, the Ministry of Labour and Social Security (MLSS) increased its capacity to improve the HIV Workplace response. The Ministry developed training curriculum to build legal literacy and capacity of key ministry staff to address labour-related issues and concerns of PLHIV and KPs. The steering committee that was established in 2015, comprised of Directors and Senior Managers from the various departments and agencies of the ministry, managed and supported the further integration of an HIV response in the Ministry's operations and plans vis a vis the various departments and agencies.

The OSH Bill is currently at the Chief Parliamentary Counsel (CPC). It is expected that the corrections will be settled in 2017 with a view of it being passed to the Legislative Committee of Parliament. Once this final stage in the legislative process is passed, then it should be ready for tabling in Parliament in 2017.

TPDCo

In keeping with activities that align with implementing HIV workplace programmes the TPDCo through its TEAM Jamaica and Tour guide programme conducted 107 sensitization/awareness sessions reaching a total of 2,357 persons in 2016. Twenty-five (25) consultations occurred to further discuss the implementation and expansion of their HIV and AIDS Workplace Policies initiatives. Within the wider tourism sector 13,450 lubricants, 40,450 male and 2,090 female condoms were distributed and 1,853 persons were tested for HIV and Syphilis. The MOT recognized both World AIDS Day and Safer Sex Week with activities that served to sensitise and educated persons about HIV risk and prevention related content.

9.6.2 Legal Literacy

A committee was established to oversee the MLSS's implementation of the Global Fund Project, which sought to further reduce stigma and discrimination associated with HIV in the workplace. This is in keeping with policy direction and requirements of the National Workplace Policy on HIV and AIDS and the Voluntary Compliance Programme, both of which seek to strengthen the legal framework for providing redress for Persons Living with HIV (PLHIV) who have experienced discrimination in the workplace. The committee is comprised of a number of key Ministry personnel and partners from the wider HIV response. A consultant was also engaged to coordinate and facilitate Legal Literacy capacity building activities for key ministry personnel in relation to the NWP. As such between August and September, six capacity development workshops were conducted and Ninety Six (96) members of staff were reached from: Pay and Conditions of Employment Branch (PCEB), Industrial Relations (IR) Division, Documentation Information and Access Services (DIAS), The Occupational Safety and Health Department (OSHD), Industrial Disputes Tribunal (IDT) Legal Services Division and the Human Resources and Administration Department.

9.6.3 Capacity Building

The MLSS HIV Unit attended a three-day residential training, which introduced a human rights curriculum that explored Jamaica's human rights landscape and examined sexual and reproductive health. The curriculum speaks broadly to human rights and equips participants with relevant human rights information, which can be integrated into their work in the various agencies and organizations.

10.0 Commitment 10: Commit to taking AIDS out of isolation through people-centred systems to improve universal health coverage, including treatment for tuberculosis, cervical cancer and hepatitis B and C.

10.1 Universal Health Coverage

In January 2016, the national treatment guidelines were updated to include the recommendations set out in the WHO 2013 guidelines, antiretrovirals should be offered to all patients with a CD4 count of less than 500. Commencement of antiretroviral therapy was recommended for the following conditions, regardless of CD4 count: pregnancy, active Tuberculosis, Hepatitis B, and HIV Associated Nephropathy. Pregnant women were offered treatment at diagnosis and to be continued for life, hence, advancing universal health coverage.

Other national response initiatives geared to this objectives is FAMPLANs commitment to consistently offering sexual reproductive health counselling, cervical and breast cancer screening, prostate cancer screening Hep B screening and vaccination, vulnerable policy and quality of care systems implemented at clinical level/service delivery level.

10.1.1 HIV/Tuberculosis Co infection

The TB/HIV manual for health care providers to support delivery of care to persons with TB and TB/HIV co-infection was updated with support from PAHO while The National Tuberculosis Programme which is currently subsumed by the HIV/STI/Tb Unit, is an attempt to maximize efficiency in the management of Tb and HIV/Tb co infection. Patients diagnosed with the latter are managed at one of the two main treatment sites across the island for a period of eight weeks (intensive phase) following which the maintenance phase of therapy is continued for another four months. The initiation of ART in these patients is dependent on the patient's clinical status and CD4 counts.

Challenges

Challenges continue in 2016:

- Lack of availability of direct sputum testing and GeneXpert tests which has hampered diagnosis and test of cure;

Table 9: Tuberculosis Data 2011-2015

Cases	2011	2012	2013	2014	2015
Number of TB cases Detected	118	95	104	86	147
Number Screened for HIV	90	72	95	79	87
Percentage (%) of TB Cases Screened for HIV	76	76	92	92	100
Of TB Cases Screened number Co-infected	17	16	16	19	27
Percentage of TB cases Co-infected (of those screened)	18.88	22	16.84	22	18.36

In spite of this, active case finding through contact tracing has led to an increase in identification of cases over the reporting period with 41% more suspected cases being identified over a similar period in 2014. The burden of HIV/Tb co infection was approximately 18 % of total suspected cases for 2015. Efforts to streamline the NTP include the completion of the Tb management protocol.

10.2 National Strategy

The major strategic investments of national response in 2016 in Jamaica were the continued process for integration of sexual and reproductive health and HIV at service delivery level; the costing of the NISP; completing a transition assessment report in preparation for a sustainable AIDS response post donor funding; completing the sustainable index dashboard and the on-going contributions of the MERG.

10.2.1 Integration of Sexual and Reproductive Health and HIV

In 2013 the Jamaican Government gave approval for the integration of certain components of the National HIV/STI Programme into the NFPB. The components that were integrated were:

- Support to Treatment and Care Services
- Prevention
- Enabling Environment and Human Rights
- Monitoring and Evaluation

The overall direction and leadership of the response currently lies with the National Family Planning Board - Sexual and Reproductive Health Agency. It has the legal status and mandate to autonomously manage and coordinate the national response with formal reporting relationships to government authorities at ministerial and administrative levels. While coordination of the response lies with the NFPB-SRHA, the four regional health authorities have the responsibility of implementing programmes and services at the regional level. Further, other ministries - Ministry of Labour and Social Security; the Ministry of Industry and Tourism; the Ministry of Education; the Ministry of Youth and Culture; the Ministry of Local Government; Ministry of Justice and the Ministry of National Security - will also continue to implement HIV response programmes.

The central Ministry of Health has retained those aspects of the former National HIV/STI Programme - now known as the HIV/STI/Tb Unit in the Ministry of Health - that currently focus on Policy, Treatment and Surveillance, Quality and Standard Setting. The role of civil society organisations in further expanding the response at community level and enhancing the importance of community systems strengthening as an integral component of health systems strengthening is critical and in this regard, the input of civil society organisations is vital.

To date, the integration of the HIV Programme into the NFPB-SRHA may be described as administrative as well as operational. A Service Level Integration Committee has been formed in order that the country may advance the process of integration of HIV and family planning. The Service Level Integration Steering Committee met consistently in 2016 with the aim of planning for the structured integration of sexual and reproductive health (SRH) and HIV at service delivery level. Information was presented to attendees on integration options, which included examples of successful models of integrated care as well as several regional presentations about the current status of integration in the clinics, current integration examples, and challenges.

Two major components are essential to operationalize the concept of integrating HIV into family and population planning services of the NFPB-SRHA: the first is the efficient management of resource flow; the second, **to address the enabling conditions needed at service level and the specific facilities at which such services can be integrated.** Conventional approaches discussed in various international literature suggests that integration of health services must be contextual; backed by local data and empirical evidence, taking into consideration appropriate policies, management systems with a coordinated structure, multi-stakeholder involvement, R&D and indigenous resources. However, there is a need to better frame what constitutes operationalizing integrated services and to guide national and local authorities to develop a frame work for integrated services. The aim is to identify an effective framework for integration at the service delivery level and insight into how the Committee will take the process of the integration at the service delivery forward in a sustainable environment and in a strategic manner. The integration process is proposed to commence with a pilot in two facilities (type 3 and type 5, or urban and rural). Efforts are also being explored about potential resources to support the process of integration.

Within this context, the immediate next steps include processes to:

- Conduct a literature review and synopsis, including mapping, of relevant, existing best practices reflecting service level integration of family planning services into HIV/AIDS Treatment and Care services or vice versa
- Conduct an analytical study/assessment of various approaches and policy practices to integrating family planning services within the context of strengthening primary care services in Jamaica
- Recommend models of integration that are in alignment with MOH priorities, policies and guidelines
- Identify a minimum package of services based on needs assessment of the clients
- Develop a Monitoring and Evaluation frame work for the services to be integrated

10.2.1 Costing of the National Integrated Strategic Plan for Sexual and Reproductive Health and HIV 2015-2019 (NISP)

In 2016 Jamaica finalized costing of the National Integrated Strategic Plan for Sexual and Reproductive Health and HIV 2015-2019 (NISP) with financial support from the UNJT on AIDS. The Implementation Matrix of the NISP was used to derive the estimates required for the costing. The estimates were broken down into Priority Areas and these costs were further analysed by Strategic Outcomes and Output. Thereafter, the estimates were presented in the format of a Stylised Resource Needs Model that was adjusted to incorporate and reflect the activities as portrayed in the Implementation Matrix.

10.2.2 Costs of the NISP - Implementation Matrix Format

The annual costs of years 1 to 5 and a breakdown of the Final Cost of the five Priority Areas are noted below:

**Table 10: Estimate of the Cost of Jamaica's NISP by Priority Area per year
Implementation Matrix Format**

(US\$ Millions)

	Priority Area	2014/15	2015/16	2016/17	2017/18	2018/19	TOTAL	% Share of NISP
1	<i>Prevention and SRH Outreach</i>	7.1	5.5	6	6.3	6.4	31.3	19
2	<i>Universal Access to Care, Treatment and Support and SRH Services</i>	18.7	20.2	22.5	24.4	26.8	112.6	67
3	<i>Enabling Environment and Human Rights</i>	1.9	2.3	2.3	2.2	2.3	11.0	7
4	<i>Monitoring and Evaluation</i>	0.6	0.9	0.7	0.7	0.9	3.8	2
5	<i>Sustainability, Governance and Leadership</i>	1.5	2	2.2	2.2	2.3	10.1	6
	TOTAL	29.8	30.9	33.7	35.8	38.7	168.8	101

NB: Some totals may not sum to 100 due to rounding

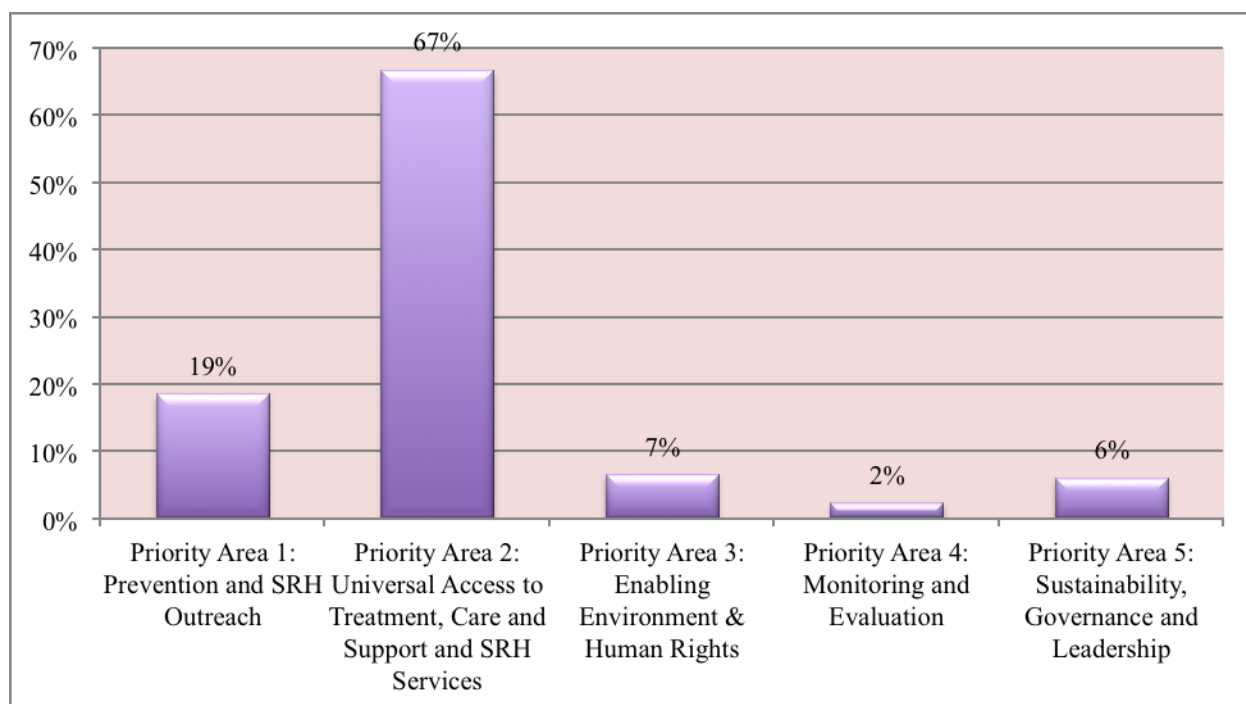
The cost breakdown for the five-year period shows that the estimated implementation cost for 2014/15 totals US\$29.8 million while the 2018/19 estimate is US\$38.7 million. The delivery of the strategic activities identified in *Priority Area 2, Universal Access to Treatment Care and Support and SRH Services* accounts for US\$112.6 million and this represents 67 percent of the overall cost of implementing the NISP over the five-year period. Outputs or programmes included in this Priority Area on which costs are applied include: expanded HIV testing and

counselling, elimination of vertical transmission of HIV and syphilis and the establishment of integrated family planning and maternal and new-born health.

Priority Area 1, Prevention and Sexual and Reproductive Health (SRH) Outreach absorbs the second highest share of the NISP over the entire period. It amounts to US\$31.3 million, which amounts to 19 percent of the overall Plan. Activities include procurement and distribution of supplies to develop and implement a comprehensive package of family planning services to reduce unplanned pregnancies and address unmet family planning needs. Prevention interventions also focus on at risk groups including Persons with Disabilities (PWD) and the Elderly.

Over the period the other three Priority Areas together, account for approximately 14% of the entire cost of the NISP. *Priority Area 3, Enabling Environment and Human Rights* absorbs about US\$11 million or 7 percent of the total cost and *Monitoring and Evaluation, Priority Area 4*, accounts for just about US\$3.8 million or 2 percent and *Priority Area 5, Sustainability, Governance and Leadership* was estimated at 6 percent of the entire programme; this cost amounts to US\$10.2 million. Figure, 8 below further illustrates the percentage breakdown of the total cost into Priority Areas.

Figure 8: Total Cost of Jamaica NISP by Priority Areas Implementation Matrix Format



10.2.3 Costs of the NISP – Stylized Resource Needs Model Format

The Stylised RNM format presents the cost of the NSP under the following broad categories shown in table 11 below.

Table 11: Distribution of NISP Costs as per the Resource Needs Model

	PRIORITY AREA	Costs (5 Year) (US\$ million)	% Share of Total NISP
1	<i>Increasing National Commitment (Sustainability, Governance)</i>	10.16	6.02
2	<i>Prevention</i>	39.25	23.25
3	<i>Treatment and Care</i>	104.67	62.00
4	<i>Capacity Building (Enabling)</i>	11.02	6.53
5	<i>Research (Monitoring & Evaluation)</i>	3.72	2.20
	TOTAL NISP	168.82	100

Treatment and Care accounts for the largest share of the total cost (62%). This includes the costs of ARV treatment, which were costed as per targets laid out in the NSP. It also incorporates Human Resource and other programme costs. *Prevention* follows with an estimated cost of US\$39.25 million and together with Treatment and Care constitute close to 85% of the overall cost. The remaining 15% is distributed among *Governance Advocacy and National Strategic Planning, Capacity Building/ Enabling Environment* and *Research/ Monitoring & Evaluation*.

10.2.4 Post Donor Funding Transition Preparedness Assessment

The Jamaican government completed a post donor funding transition preparedness assessment as part of the preparation for a sustainable AIDS response. The process was led by the Planning Institute of Jamaica and the Ministry of Health with support from a multi sectoral and multi-disciplinary Steering Committee. The UNJT on AIDS partnered with the Global Fund and USAID in giving the country support. The assessment examined the country's disease program readiness for transition from external support and considered the factors affecting HIV program sustainability and also aimed at informing a smooth and effective transition planning process from the Global Fund support in Jamaica. It utilized mixed methods of data collection entailing desk review, analysis of secondary quantitative data and in-depth interviews to identify areas of high, moderate or low risk for successful transition and outlines necessary steps towards programming for sustainable transition. Assessment informants included government officials, donor representatives, staff from international organizations, and civil society members, among others. The results of the assessment will be reported in subsequent GAMS as it was validated outside of the reporting period.

10.2.5 The Sustainability Index Dashboard

To better understand the progress towards sustainability and to make informed investment decisions, Jamaica participated in the PEPFAR's Sustainability Index and Dashboard process for two consecutive years using the associated tool. The tool assesses the HIV and AIDS sustainability across 15 critical elements² outlined under the broad headings;

- Institutionalized data availability
- Domestic Programme and service delivery
- Health Financing and strategic investment
- Accountability and transparency
- Enabling environment

The results were used to inform the transition preparedness assessment.

10.2.6 Jamaica Monitoring Evaluation Reference Group (J-MERG)

The Jamaica Monitoring and Evaluation Reference Group (J-MERG) was established in 2006 to strengthen the development and implementation of the National Monitoring and Evaluation System and to support the implementation of the National Integrated Strategic Plan for Sexual and Reproductive Health and HIV (NISP 2014-2019).

One key function of the MERG is to be an independent national advisory body of influential partners, policy experts and key thinkers in HIV, STI, monitoring, evaluation and research. These partners would provide guidance to the national HIV response in the generation, dissemination and use of HIV strategic information and foster functional M&E performance in Jamaica.

The MERG aims to define, endorse, disseminate as well as follow-up the national M&E agenda, based on best practices and international standards.

Its overall core responsibilities are to:

- I. review and endorse national M&E norms, standards and tools, including the national integrated strategic plan and the requisite document;
- II. strengthen the M & E alliances, coordination and harmonization mechanism among Government, civil society, and private sector. Tighter coordination and synergy has been established in the development of partners, for knowledge sharing, analysis and use of M & E information products;
- III. lead and deliver reports on the progress of the National M&E plan. This is being done via work plan agreements (per technical working groups) which should track the National

Family Planning Board (NFPB) and the Ministry of Health (MOH's) M & E activities, identify gaps and provide remedial actions where relevant.

The J-MERG comprises four technical working groups, namely:

- a) Evaluation, which aims to provide technical support to the evaluation of programmes in the sexual and reproductive health response including HIV and Family Planning.
- b) Research Agenda which main objective is to develop and monitor a plan that will ensure congruence between data needs and data collected and will facilitate the “know your epidemic” concept.
- c) Data Sharing & Data Use, which sought to improve the availability, quality, and use of data related to the HIV epidemic through the development and implementation of a communication strategy and provide support to the development of user-friendly information tailored to specific audiences that will facilitate strategic use of collected data.
- d) Guidelines for Key Populations which aims to guide the operationalization of the guidelines for monitoring and evaluation of HIV programmes for sex workers, men who have sex with men and transgender people.

The technical working groups have been instrumental in:

1. mapping key M & E stakeholders and information product
2. fostering M & E networking and M & E capacity building processes
3. establishing a national database of trainers and technical assistance providers
4. designing and implementing a M& E Communication and Dissemination Plan with implementation on the way.

10.3 Monitoring and Surveillance

10.3.1 Monitoring

The NFPB and the MOH Monitoring and Evaluation Units, focused on several key areas for 2016. Among them are the programmatic monitoring of the prevention and enabling environment and human rights' activities, the implementation of the Unique Identification Code

(UIC), the advancement of web-based databases (using the DHIS2 platform) for HIV treatment and for HIV prevention services; dubbed the Treatment Services Information System (TSIS) and the Prevention Services Information System (PSIS) respectively and improving hardware capacity.

10.3.2 Programmatic Monitoring

The monitoring of the prevention and enabling environment and human rights' activities continues to be a major function of the national HIV/STI response. The monitoring of these activities take the form of periodic updates on national key population reached and tested indicators and monthly technical progress reports. The updates and progress reports provide an illustration on the current performance of the national response against the overall targets. This also gives an overall progress on donor-funded activities.

10.3.3 Unique Identification Code (UIC)

Jamaica has also made significant progress in the implementation of the Unique Identification Code (UIC) for key population. The UIC was developed as a means to measure the number of key population reached and tested through a comprehensive package of services for HIV prevention by NGOs and RHAs. With the assistance of the Population Services International (PSI) team, the UIC roll-out has made significant progress across all health regions and NGOs is underway.

The country's HIV response is now in the process of mainstreaming data entry, validation and analysis of the UIC through the use of the District Health Information System version 2 (DHIS 2). All prevention sites have been assessed for readiness to accessing and implementing the system.

Sensitization has been done by PSI, involving a wide cross-section of stakeholders from Government, civil society and international donor partners. Here, stakeholders were able to agree on the format that the UIC would take, and how it should be effectively executed. The UIC

Outreach Register and Information Flow were also finalised. A Data Security Protocol was also developed.

Computers, servers, air condition unit (for server), filing cabinets, and other pertinent equipment were purchased to accommodate the efficient national roll-out of the UIC.

10.3.4 Database Development

Prior to the development of the web-based solution, the HIV treatment sites had stand-alone databases that did not ‘speak’ to each other. This made it difficult to track and manage patients that sought care at multiple sites, provide technical support in terms of trouble-shooting and collate data for national analysis and reporting. The prevention services did not have a standardized database used universally by the respective prevention teams previously; but with the implementation of the UIC in 2016, it became critical for one to be developed. The implementation of these data systems will thus enable both the HIV treatment sites and prevention services to be able to see a comprehensive history of services received by that client, de-duplicate clients seen across multiple access points in real time, while still being able to update the services provided by their respective agency.

The design of both databases was completed in 2016 with support from the developers of DHIS2 in Uganda. For the Treatment Services Information System, regional sensitizations were held. End-users, including staff with management responsibility and those who would be interfacing directly with the system, were shown demonstration of the said system, and were given the opportunity to provide feedback that was subsequently incorporated. A similar process was also done for the Prevention Services where a demonstration was done with key stakeholders in the UIC technical Working Group followed by a pilot with actual data from the UIC forms.

Improving Hardware Capacity

In addition to the database development, investments were also made in improving the hardware capacity at national and sub-national levels to support the hosting of these web-based databases at MoH and the NFPB respectively, as well as the remote connectivity of the sites through

secured internet connections. The rollouts of these web-based information systems are being done on a phased basis that will continue in 2017.

10.4. Research/Evaluation

Six main evaluation and research related activities were coordinated by the M&E units of the NFPB and MOH in 2016: Assessments of service delivery and their effectiveness and of Healthcare services for LGBTQI students and Staff at UWI, evaluation of the linkage to care and case management practices, an analysis of the National AIDS Spending, a qualitative assessment for key population status and the annual HIV sero-survey among antenatal and STI clients.

10.4.1 Assessment of service delivery and their effectiveness

The NFPB Unit conducted a total of thirteen (13) site visits over the reporting period (for prevention and EEHR). The purpose of the evaluation was to assess the overall service delivery and their effectiveness. A synopsis of the results are as stated hereunder:

1. Activities tailored for the In and Out-of-School-Youths (OSYs) have been beneficial to students. An assessment of the Hold-On-Hold-Off Intervention performance revealed effectiveness in terms of its messages.
2. Visits to the female Sex Worker sites revealed serious gaps, which potentially placed the Behaviour Change Coordinators (BCC) and Community Peer Educators (CPEs) at occupational risks. Some of these were the absence of hazard bags, Lysol spray, and portable chair.
3. The Clinic and workspaces to serve persons living with HIV were inadequate.

10.4.2 Evaluation of Linkage to Care

Under the USAID project, the NFPB evaluated the linkage to care and case management practices in selected outreach settings. The focus of the assessment examined the referrals and linkages to care as part of the ‘Continuum of Care and the HIV treatment cascade. The assessment found that while referrals and linkages to care has been part of the public and civil

society sectors dialogue for quite some time, implementation has not yet been formalized or standardized in either sector. Staff was trained to use the relevant protocols that were disseminated around 2014-2015.

Another key finding was that the referrals, linkages and retention in care were threatened by the discriminatory attitudes of some healthcare workers towards MSM, the lengthy waiting times at clinics, and medication stock-outs.

10.4.3 Assessment of Healthcare services for LGBTQI students and Staff at UWI

The National Family Planning Board in collaboration with the University of the West Indies HIV and AIDS Response Programme (UWIHARP) has entered into a Service Level Agreement to embark on a research titled, “Investigating the access to healthcare services (specifically HIV and sexual and reproductive health services) for LGBTQI students and staff at the UWI Mona Campus.” The study proposes to explore the issue from the perspectives of the users of the services, persons offering the services, managers of the services and also general campus managers. The study will be conducted over a three-year period (as per the service level agreement between UWIHARP and the MOH through the NFPB-SRHA).

10.4.4 The National AIDS Spending Assessment (NASA)

The NASA is an expenditure analysis that follows a standardized methodology put forth by UNAIDS. This is the third time Jamaica has undertaken this analysis, and in keeping with the previous exercises, this assessment covered two financial years: April 2013 – March 2014 and April 2014 – March 2015. It has been repeatedly noted though that the delayed retrieval and analysis of this data is tedious to collect and limits the usability of results. Hence, another NASA initiative is already being planned for the 2015/2016 financial year. This iteration should also include the institutionalization of this specific data capture within routine data reporting frameworks that will facilitate timelier and easier collation of this data; and thus be more useful in supporting evidence-based resource allocations.

10.4.5 Assessment of Key Populations

The assessment for KP-status capture in clinical settings was a qualitative assessment among both KP members and health care workers using focus group discussions and in-depth interviews. It explored the barriers and enablers to KP members disclosing their KP status in clinical settings; and health care workers' comfort in eliciting this information systematically. The findings will guide the upcoming training of providers and also

10.4.6 HIV Sentinel Surveillance Sero-Survey

Finally, the HIV sentinel surveillance sero-survey is conducted each year to help determine HIV prevalence rates in the general and at risk populations. HIV tests are routinely offered to both group of clinic attendees but the survey involves additional data capture and submission during the data collection period. A sample size is calculated and proportional quotas based on clinic populations are assigned to each of the six sentinel sites: three urban and three rural. Participants are conveniently selected for inclusion in the survey between the ages of 16 and 49 years until the respective quotas have been met.

10.5 Capacity Building for Monitoring and Evaluation

10.5.1 Preparation of field staff for the change in national guidelines for HIV management

Another area of focus in 2016 for the M&E Unit at MoH was the preparation of field staff for the change in national guidelines for HIV management to become more aligned with the WHO 2015 recommendations. The M&E team members participated in joint site visits with members from Treatment, Care & Support at parish level meetings. A presentation highlighting the WHO 2015 guidelines to be adopted was shared followed by discussions concerning the measures that needed to be in place in preparation for these changes.

10.5.2 Capacity building through training of treatment site staff

A CARPHA-led assessment of M&E capacity of staff in treatment sites in 2015 underscored the fact that the focus of M&E for treatment at sub-national levels continued to be solely on reporting. There is no dedicated staff with sole responsibilities for M&E function. Several individuals noted that they did not perceive themselves to be adequately equipped to perform the necessary data analysis to inform their operations at a local level. This mirrored findings from a previous assessment done in 2008. As such, capacity building through training of treatment site staff continued to be a priority for the M&E unit at the Ministry of Health. In 2016, both a basic and an advanced M&E skills training workshop were coordinated for treatment sites including middle managers and site coordinators. The Basic M&E Skills Training followed the CARPHA curriculum and emphasized the definitions of monitoring and evaluation, the development and use of logic models, indicators and data quality. The Advanced M&E Skills Training was delivered in partnership with CARPHA but primarily followed the modules developed by MEASURE Evaluation for Data Appreciation and Data Utilization.

There was also opportunity for internal capacity building of M&E members at the Ministry of Health. Although Jamaica has been able to generate treatment cascades for PLHIV over the past few years, one for the key populations (KP) had not been generated. The biostatistician from the M&E unit (MoH) was thus given the chance to participate in a regional training hosted by CDC that provided support to generate a national KP treatment cascade for the first time.

10.6 Strengths, Challenges and the Way Forward

Developed around the 12-component M&E framework proposed by UNAIDS, Jamaica has a relatively advanced M&E system that is able to collect and analyze data from multiple data sources, including planned and budgeted research studies. Operational guidelines for M&E are available and updated periodically; and the culture of routinely using the data to guide programme design exists. Jamaica's M&E also benefits from strong organizational partnerships with other agencies that support system strengthening for the availability and quality of strategic information to guide decision making.

Fragmentation of data systems is a challenge though, particularly among the data systems for treatment of PLHIV at the clinics, HIV surveillance and testing at the national laboratory. The MoH recognizes that this fragmentation contributes to inefficiencies and missed opportunities to improve availability and quality of data used for patient management and reporting. In 2017, a priority of the Ministry of Health, through support from the CDC, is therefore to develop a solution so that the various data systems can become more connected and integrated.

Underreporting is another major challenge that the M&E Unit at Ministry of Health faces. While it had always been suspected, it has now has been able to be confirmed through data triangulation exercises; and quantified through the audit of the HIV case-based surveillance system that was conducted in 2016. In partnership with the National Surveillance unit, the M&E unit will be focussing on helping the parishes to identify and improve systematic weaknesses that consistently contribute to this gap in data quality which will in turn, strengthen the decisions that these data inform.

Finally, the MoH has long recognized that while important, training in and of itself is insufficient to address the capacity gaps for M&E at a sub-national level. Therefore, a key activity for M&E in 2017 will be conducting an assessment for human capacity for M&E, particularly at sub-national levels, in collaboration with CARPHA. This will be used to inform a human capacity plan to strengthen the overall M&E capacity.

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Annex 1: Preparation Process for NCPI Completion - Jamaica's Global AIDS Response Report, 2017

Activities

- 1. Initial meeting, stakeholders list developed**
 - 2. Email relevant sections of the tool to stakeholders**
 - 3. Stakeholders meeting –consolidated tool completion**
 - 4. Analysis of responses, development of a master tool with completed responses highlighting areas of discrepancy.**
 - 5. Email completed tool to stakeholders for first phase of validation**
 - 6. Document draft NCPI Narrative report**
 - 7. Validation meeting – second phase of validation**
 - 8. Finalize NCPI Narrative report**
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Annex 2: Funding Matrix

Annex 3 Participants in NCPI and GARPR Consultations

List of Attendees – NCPI Consultation February 23, 2017	Representatives
National Family Planning Board - Sexual and Reproductive Health Agency	Nicola Cousins
Jamaica Network of Seropositives	Althelia McLoed
Ministry of Health	Jennifer Tomlinson
Jamaica Network of Seropositives	Loraine Graham
National Family Planning Board - Sexual and Reproductive Health Agency -GIPA	Ainsley Reid
	Dianne Thomas
United States Agency for International Development	Sacha-Marie Hill
United States Agency for International Development	Jennifer Knight-Johnson
Jamaica AIDS Support for Live	Patrick Lalor
National Family Planning Board - Sexual and Reproductive Health Agency	Roshane Reid
Jamaica Coalition of Positive Women	Althea Cohan
Ministry of Health	Sasha Martin
Eve for Life	Oral Higgins
JFLAG	Glenroy Murry
Jamaica Network of Seropositives	Ricky Pascoe
National Family Planning Board - Sexual and Reproductive Health Agency	Devon Gabourel
Division of Correctional Services	Donna Royer-Powe
Jamaica Network of Seropositives	Sue Ann Wallace Brown
Jamaica Network of Seropositives	Nadine Lawrence
National Family Planning Board - Sexual and Reproductive Health Agency - Ministry of Labour and Social Security	Conrad Saunders
National Family Planning Board - Sexual and Health Reproductive Agency	Amoy Douse-Mullings
National Council on Drug Abuse	Gwen Akinlosotu
National Family Planning Board - Sexual and Reproductive Health Agency	Marvin Josephs
Pan American Health Organization	Sheila Samiel
Red Cross	Agoutinto Pinnock
ASHE	Conroy B Wilson
	Kristoph Wilson
Health Policy Plus	Sandra McLeish
Jamaica AIDS Support for Life	Kandasi Levermore
Joint United Nations Programme on HIV and AIDS	Eva-Jean Stevens

CVC/CCM	Ivan Cruckshank
NCPI/GAM Consultant	Jennifer Stuart-Dixon
CVC	Sannia Sutherland
United States Agency for International Development	Nkensani Mathabathe
List of Attendees – Stakeholder’s Working Group March 10, 2017	Representatives
National Family Planning Board - Sexual and Reproductive Health Agency	Dr. Denise Chevannes
National Family Planning Board - Sexual and Reproductive Health Agency	Tazhmoye Crawford
M.O.H	Tameka Clough
National Family Planning Board - Sexual and Reproductive Health Agency	Andre Black
National Family Planning Board - Sexual and Reproductive Health Agency	Marvin Joseph
National Family Planning Board - Sexual and Reproductive Health Agency	Damion Grant
FamPlan	Marjorie Samuels
MLSS	Conrad Saunders
United States Agency for International Development	Sasha-Marie Hill
Attorney General’s Chamber	Chantal Bennett
Ministry of Education, Youth and Information	Anna-Kay Magnus Watson
National Family Planning Board - Sexual and Health Reproductive Agency	Danielle Henry
National Family Planning Board - Sexual and Health Reproductive Agency	Christina Walker
Ministry of Foreign Affairs	Nicholette Williams
National Family Planning Board - Sexual and Health Reproductive Agency	Nicola Cousins
Jamaica Family Planning Association	St. Rachel Ustanny
National Family Planning Board - Sexual and Health Reproductive Agency	Ainsley Reid
NFPB-SRHA	Denise Chevannes
Women Centre	Beverley Martin-Berry
North East Regional Health Authority	Tamika Henry
Health Policy Plus	Sandra McLeish
UNAIDS	Erva-Jean Stevens
Ministry of Health	Zahra Miller
UWI HARP	Yolanda Paul
National Family Planning Board - Sexual and Health Reproductive Agency	Andrea Campbell
Jamaica Network of Seropositives	Ricky Pascoe
Western Regional Health Authority	Cheryl Belcher-Peart

NCPI/GAM Consultant	Jennifer Stuart-Dixon
List of Attendees – Validation Meeting March 24, 2017	Representatives
MOH	Sasha Martin
MOH	Nichole Martin Chen
Rapporteur	Sheryll Thomas
NFPB-SRHA	Roshane Reid
NFPB-SRHA	Damion Grant
MLSS	Marlon Mahon
MLSS	Conrad Saunders
PAHO	Sheila Samiel
MOH (HSPI)	Richard Musaaazi
UNICEF	Donneth Edmondson
NCPI/GAM Consultant	Jennifer Stuart-Dixon
NFPB-SRHA	Marvin Joseph
UNAIDS	Erva-Jean Stevens
UNAIDS	Nkensani Mathabathe
MoH	Zahra Miller
JN+	Jumoke Patrick
MOH	Kelly-Ann Gordon Johnson
JASL	Xavier Biggs
Eve for Life	Renee Johnson
JN+	Sue-Anne Wallace Brown
CVC/CCM	Ivan Cruckshank
CVC	Sannia Sutherland
CVC	Kristina Mena
NFPB-SRHA	Nicola Cousins
Jamaica Family Planning Association	Marjorie Samuels
AGC	Chantel Bennett
Ministry of Foreign Affairs and Foreign Trade	Nicholette Williams
North East Regional Health Authority	Tamika Henry
MOH	Jennifer Tomlinson
NFPB-SRHA	Andrea Campbell
NFPB-SRHA	Dianne Thomas
NFPB-SRHA	Tazhmoye Crawford
NFPB-SRHA	Danielle Henry
JN+	Ricky Pascoe
