Jamaica Report NCPI

NCPI **Header**

is indicator/topic relevant?: Yes
is data available?: Yes
Data measurement tool / source: NCPI
Other measurement tool / source:
From date: 02/18/2014
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Additional information related to entered data. e.g. reference to primary data source, methodological concerns::
Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source::
Data measurement tool / source: GARPR

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Describe the process used for NCPI data gathering and validation: Jamaica has maintained a rigorous approach in conducting NCPI 2012–2013. An initiation workshop was held in which the methodology for implementing the NCPI was reviewed with key stakeholders. At that workshop the team of interviewers that were selected from both civil society, government and UN partners were introduced. An effort was made to have civil society interviewers interviewing government officials and vice versa. This allowed for more transparency in the data collection process. The diverse stakeholder responses were summarised in the respective subsections of the questionnaires. The desk review was extensive and examined a number of legislation, reports and policy of the country, which aided in the validation process. However, areas needing further validation were presented at a validation workshop in which stakeholders conferred among themselves to provide appropriate responses that addressed the validation questions.

Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions: Disagreements were resolved within their respective stakeholder groups by reviewing the literature to identify what had been documented in national programme or civil society reports. Other areas of disagreement were discussed by the management team and brought to the stakeholders for validation.

Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like): 1. The changing nature of the tool makes a trend analysis difficult as sections change as priority areas change and country programmes develop. This example is clearly depicted in Parts A and B, which share a component called political support and leadership yet the indicators have little in common on which to compare and analyse. 2. There is no standard benchmark that guides the ratings of the tool. As stakeholders' and perspectives change so does the rating for the tool. This questions the validity of using and comparing the findings overtime. 3. In Part B, subsection 5 – Treatment, Care and Support (TCS), question 3 read 'TCS" when it should have read "OVC" similar to Part A. This question had to be redone at the validation workshop for civil society stakeholders as they had responded and rated the incorrect issue.

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

Organization	Names/Positions	Respondents to Part A
National HIV Programme	Ms. Terri Myrie/Enabling Environment and Human Rights	A2
National AIDS Committee	Ms. Carla Ledgister/Vice Chair	A2,A3,A4,A5
National HIV Programme	Dr. Nicola Skyers/Director Treatment, Care and Support	A1,A2,A3,A4,A5
Ministry of Tourism	Ms. Sheryll Lewis/TPDCo	A2,A3
Ministry of National Security	Dr. Donna Royer-Powe – Director of Medical Services/Department of Correctional Services	A2,A3,A5
National HIV Programme	Dr. Jeremy Knight/Director	A1,A2
CHART/ERTU	Dr. Tina Hylton-Kong/Clinical Coordinator	A5
National HIV Programme/NFPB	Dr. Sharlene Jarrett/Senior Director, M&E	A1,A2,A3,A6
Ministry of Health	Dr Sonia Copeland	A1,A2
Bureau of Women's Affairs	Ms. Karen Small/Gender Analyst	A2
National HIV Programme/NFPB	Mrs. Sannia Sutherland/Acting Executive Director	A1,A2,A3,A4,A5,A6
National HIV Programme/NFPB	Mrs. Karlene Temple Anderson/Director, Enabling Environments & Human Rights	A1,A2,A3
Ministry of Labour and Social Security	Mr. Robert Chung/Director	A2,A3
National Council on Drug Abuse	Ms. Collette Brown/Programme Manager & Ms. Jhanille Brooks	A1,A2,A3,A4,A5
Western Regional Health Authority	Dr. Simone Spence/Regional Technical Director	A2,A3,A4,A5
Southern Regional Health Authority	Mrs. Ennis/Reid Jones/Regional Technical Director	A2,A3,A4,A5
Planning Institute of Jamaica	Mr. Easton Williams/Director, Social, Policy, Planning and Research	A2
Ministry of Education	Mrs. Anna Kaye Magnus/National Coordinator, Health and Family Life Education	A2,A4
National HIV Programme	Mrs Zahra Miller/Director, M&E	A6
Ministry of Labour and Social Security	Ms. Christine Hendricks/National Council for Persons with Disabilities	A2,A3

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

Organization	Names/Positions	Respondents to Part B
UNDP	Rachel Morrison/HIV Programme Officer	B2
UNAIDS	Mrs. Erva Jean Stevens/Strategic Information Advisor & Mr. Lord Dartey/Rights, Gender and Community Mobilization Advisor	B1,B2,B3,B4,B5
PAHO	Dr. Kam Suan Mung/ PAHO/WHO Representative	B1,B5
HPP/Future Group	Mrs. Sandra McLeish/Jamaica Technical Advisor	B1,B3,B4,B5
Children First Youth Centre	Ms. Claudette Pious/Executive Director	B1,B3,B4
World Learning	Mrs. Ruth Jankee/Project Director for Jamaica and the Bahamas -	B1,B2,B3
Jamaica Network of Seropositives	Mr Devon Gabourel/Programe Coordinator & Ms. Paula Samuels/Board President	B1,B2,B3,B4,B5
UNESCO	Ms. Jenelle Babb/National Programme Officer for HIV/AIDS	B1,B2,B3
Jamaica AIDS Support for Life	Mrs. Kandasi Levermore/Executive Director	B1,B2,B3,B4,B5
UNICEF	Mrs. Novia Condell–Gibson/Children & HIV/AIDS Specialist	B2,B3,B4,B5
Children of Faith	Mrs. Gloria Meredeth/Executive Director	B1,B4
Hope Worldwide	Ms. Karen Daye/Programme Coordinator	B1,B2,B3,B4
Clinton Health Access Initiative	Ms. Ingrid Thame/Country Director	B1,B5
JFLAG	Mr. Jaevion Nelson/Programme & Advocacy Manager	B1,B2,B3,B5
SWAJ	Mr. Marlon Taylor	B1,B2,B3,B5
CVC	Mr. Ivan Cruickshank/Programme Manager	B1,B2,B3,B4,B5
Jamaica Youth Advocacy Network	Ms. Monique Long/Executive Director and Mr. Javan Campbell	B1,B2,B3,B4
Combined Disabilities Association	Ms. Gloria Goffe/Executive Director	B1,B2,B4
IOM	Rukiya Brown/Programme Assistant	B3

A.I Strategic plan

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

IF YES, what is the period covered: Jamaica National HIV Strategic Plan (NSP) 2012-2017

IF YES, briefly describe key developments/modifications between the current national strategy and the prior one. IF NO or NOT APPLICABLE, briefly explain why.: 1. The present NSP has added two additional priority areas over the prior NSP. These areas are Monitoring and Evaluation and Sustainability. 2. Another modification in the present NSP is that key populations (KP) are clearly defined. More focus and resources would be put toward reaching the KP and vulnerable populations for Testing, Treatment, Care and Support. 3. Implementation of One National AIDS Coordinating Authority through National Family Planning Board and National HIV Programme integration. This is a strategic objective to strengthen the programme's governance structure.

IF YES, complete questions 1.1 through 1.10; IF NO, go to question 2.

1.1. Which government ministries or agencies have overall responsibility for the development and implementation of the national multi-sectoral strategy to respond to HIV?: Ministry of Health – National HIV Programme and National Family Planning Board – National Authority for Sexual and Reproductive Health

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

Education:

Included in Strategy: Yes

Earmarked Budget: No

Health:

Included in Strategy: Yes

Earmarked Budget: Yes

Labour:

Included in Strategy: Yes

Earmarked Budget: Yes

Military/Police:

Included in Strategy: Yes

Earmarked Budget: No

Social Welfare:

Included in Strategy: Yes

Earmarked Budget: Yes

Transportation:

Included in Strategy: No

Earmarked Budget: No

Women:

Included in Strategy: Yes

Earmarked Budget: No

Young People:

Included in Strategy: Yes

Earmarked Budget: Yes

Other: Tourism

Included in Strategy: Yes

Earmarked Budget: Yes

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?: Education – Activities integrated in the curriculum of Guidance and Counselling Unit/Ministry of Education and financed through Government of Jamaica. Military/Police – Financed primarily through USAID. Transportation – This sector is not included in the national HIV response. Women – Integrated in all aspects of the HIV response.

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

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS:

Discordant couples: Yes

Elderly persons: No

Men who have sex with men: Yes

Migrants/mobile populations: Yes

Orphans and other vulnerable children: Yes

People with disabilities: No

People who inject drugs: No

Sex workers: Yes

Transgender people: No

Women and girls: Yes

Young women/young men: Yes

Other specific vulnerable subpopulations: Yes

SETTINGS:

Prisons: Yes

Schools: Yes

Workplace: Yes

CROSS-CUTTING ISSUES:

Addressing stigma and discrimination: Yes

Gender empowerment and/or gender equality: Yes

HIV and poverty: Yes

Human rights protection: Yes

Involvement of people living with HIV: Yes

IF NO, explain how key populations were identified?: Key population (KP) are identified through: a) Epidemiological data; b) Consultative meetings; c) Surveys including KAPB; d) Research studies inform the groups that comprise key populations.

1.4. What are the identified key populations and vulnerable groups for HIV programmes in the country?

People living with HIV: Yes

Men who have sex with men: Yes

Migrants/mobile populations: Yes

Orphans and other vulnerable children: Yes

People with disabilities: No

People who inject drugs: No

Prison inmates: Yes

Sex workers: Yes

Transgender people: Yes

Women and girls: Yes

Young women/young men: Yes

Other specific key populations/vulnerable subpopulations [write in]:: Homeless drug users (crack, cocaine, etc.)

: Yes

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

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

1.7. Does the multisectoral strategy or operational plan include:

a) Formal programme goals?: Yes

b) Clear targets or milestones?: Yes

c) Detailed costs for each programmatic area?: No

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

e) A monitoring and evaluation framework?: Yes

1.8. Has the country ensured "full involvement and participation" of civil society in the development of the multisectoral strategy?: Active involvement

IF ACTIVE INVOLVEMENT, briefly explain how this was organised.: 1. Repeated national and focus groups consultative meetings. 2. Through engaging Civil Society Organisations (CSO) as Sub-recipients (SRs) of funding to implement programmes to provide technical support and to report regularly on programmatic activities. 3. Establishment of technical working groups (TWG) to review and revise the NSP.

IF NO or MODERATE INVOLVEMENT, briefly explain why this was the case.:

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

1.10. Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?: Yes, all partners

IF SOME PARTNERS or NO, briefly explain for which areas there is no alignment/harmonization and why:

2.1. Has the country integrated HIV in the following specific development plans?

SPECIFIC DEVELOPMENT PLANS:

Common Country Assessment/UN Development Assistance Framework: Yes

National Development Plan: Yes

Poverty Reduction Strategy: Yes

National Social Protection Strategic Plan: N/A

Sector-wide approach: Yes

Other [write in]: Sexual and Reproductive Health – NFPB (draft)

: Yes

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

HIV-RELATED AREA INCLUDED IN PLAN(S):

Elimination of punitive laws: Yes

HIV impact alleviation (including palliative care for adults and children): Yes

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

Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support: No

Reduction of stigma and discrimination: Yes

Treatment, care, and support (including social protection or other schemes): Yes

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

Other [write in]:

:

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

3.1. IF YES, on a scale of 0 to 5 (where 0 is "Low" and 5 is "High"), to what extent has the evalua¬tion informed resource allocation decisions?: 3

4. Does the country have a plan to strengthen health systems?: Yes

Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications and children: Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications? 1. There is on-going training of health care workers (HCW) capacity through in-service training. The management and procurement system have been strengthened to buy, store and distribute medication. 2. Extensive infrastructural improvement for laboratories, and the Medical Waste Unit. 3. The upgrading of Treatment Care and Support (TCS) centres is evident by the number of staff being employed and greater access to medical services. 4. Greater efforts at integrating HIV services into several health services points, this is improving access.

5. Are health facilities providing HIV services integrated with other health services?

a) HIV Counselling & Testing with Sexual & Reproductive Health: Few

b) HIV Counselling & Testing and Tuberculosis: Few

c) HIV Counselling & Testing and general outpatient care: Many

d) HIV Counselling & Testing and chronic Non-Communicable Diseases: Many

e) ART and Tuberculosis: Few

f) ART and general outpatient care: Few

g) ART and chronic Non-Communicable Diseases: Few

h) PMTCT with Antenatal Care/Maternal & Child Health: Many

i) Other comments on HIV integration: : a. Integration of HIV Programme and the National Family Planning Board (on-going)

6. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate strategy planning efforts in your country’s HIV programmes in 2013?: 8

Since 2011, what have been key achievements in this area: 1. In 2013, the Jamaican Cabinet approved a number of components of the National HIV Programme to be integrated into the NFPB. This designates NFPB as the authority for Sexual and Reproductive Health in Jamaica. 2. Jamaica has adopted the Initiative for Eliminating Mother to Child Transmission of HIV and Congenital Syphilis. A multi-sectoral technical working group has been convened and pursues efforts to achieve this goal for Jamaica by 2015. 3. Strategies have been developed for MSM and SW to improve programme design, interventions and monitoring and reporting for these key populations.

What challenges remain in this area:: 1. Decreasing the prevalence of HIV in key population (MSM, SW and adolescents). This is within the context of continuing high-risk behaviour found within these groups. 2. High levels of stigma and discrimination (S&D) reduce access to treatment, care and support (TCS) services and creates a challenge for retention in care. 3. Sustainability of funding remains a key concern for maintaining and building on the hard-won gains of the programme. Presently, the Global Fund only supports interventions for KP, while the wider national response is relying on the shrinking national budget to assist in funding the other vulnerable groups in the epidemic. 4. There is growing concern with regard to the status of OVC and the strategic direction that is needed to ensure this group remains a priority in the national response.

A.II Political support and leadership

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

A. Government ministers: Yes

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

1.1. In the last 12 months, have the head of government or other high officials taken action that demonstrated leadership in the response to HIV?: Yes

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership: 1. The Minister of Health led the opening and presentation meeting of the integration of the National Family Planning Board and the National HIV/STI Programme. The purpose is the creation of the One National AIDS Coordinating Authority for sexual and reproductive health in Jamaica. 2. The Minister of Health made statements in Parliament that conveyed appreciation for work being done by the Ministry of Labour and Social Security (MLSS) in developing the National Workplace Policy on HIV and AIDS. 3. The Minister of Health continues to advocate with Global Fund for a change in policy with regards to grant funding for countries with a high debt to GDP ratio such as Jamaica. 4. The Prime Minister has represented the Country at the United Nations on HIV-related issues. 5. The Minister of Health has served on the PANCAP board where he has advocated for greater government resources for the sustainability of the National HIV/STI Programme (NHP). 6. The Minister of Labour and Social Security is spearheading the passage of the Occupational Health and Safety Act (OHSA) in Parliament. As it relates to HIV, the Act will protect employees who are HIV positive, and provide redress for PLHIV if they lose their jobs or are refused employment because of their HIV status. 7. Senior Government Officials in the Ministry of Education re-enforce their commitment to the Health and Family Life Education (HFLE) in schools. This is the vehicle through which HIV prevention education is taught in schools.

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

IF NO, briefly explain why not and how HIV programmes are being managed::

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

Have terms of reference?: Yes

Have active government leadership and participation?: Yes

Have an official chair person?: Yes

IF YES, what is his/her name and position title?: Mrs Yvonne Davis, JEF

Have a defined membership?: Yes

IF YES, how many members?: 25

Include civil society representatives?: Yes

IF YES, how many?: 4

Include people living with HIV?: Yes

IF YES, how many?: 2

Include the private sector?: Yes

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

3. Does the country have a mechanism to promote coordinationbetween government, civil societyorganizations, and the private sector for implementing HIV strategies/programmes?: Yes

IF YES, briefly describe the main achievements:: 1. The National Workplace Policy on HIV and AIDS as been approved as a White Paper by both houses of Parliament in 2013. All stakeholders celebrate this policy as it was forged from iterative sector wide consultations and collaboration. The policy continues to gain traction in the private sector, which also speaks well for public/private partnership. 2. Key partnerships have been forged with the Ministries of Education, National Security, Labour and Tourism and other government agencies. As a result, interventions in line ministries as part of the multi-sectoral response has become more coordinated. The Ministry of Labour and Social Security has institutionalized routine HIV screening and risk reduction activities for migrant labourers, while Ministry of Tourism has implemented outreach HIV testing for their most at risk workers, that is those who are most likely to be involved in sex tourism. 3. A wide range of civil society organisations and stakeholders have been involved in the prevention response despite challenges of limited technical capacity and resources and sustainability of programmes. Some CSOs have facilitated access to persons most at risk who are often hard to reach. 4. Twenty-five (25) civil society organizations are now involved in the national response. This is a significant increase from three (3) in 2006. 5. The JCCM works closely with government on advocacy, IEC and resource development for stakeholders. 6. Convening of national annual reviews, regional (within Health Authorities) meetings have diverse multi-stakeholder involvement. 7. Minister of Education and Permanent Secretary speak positively about the HFLE programme in the newspaper, radio and television. The Ministry has: a. Pushed for the implementation of HFLE curriculum for grades 10 & 11. b. Published a bulletin, which reinforces the teaching of HFLE and the dedicated number of hours to the HFLE curriculum.

What challenges remain in this area:: 1. There has been insufficient ownership of the HIV response by critical government sectors. The level of involvement has often been limited to HIV education for staff. However, the few policy initiatives within sectors have resulted in a more supportive environment for sustaining safer sexual behaviours. 2. There is limited buy-in from important tourism principals. 3. CS continue to be hampered by limited technical, financial and human capacity. Although

some of these organizations have worked in HIV prevention for decades they have been unable to scale up coverage due to limited resources and over dependence on a single source of funding. 4. The Private sector can be a key partner in championing the cause of HIV in Jamaica. However, Private sector partnership remains a challenge. 5. There is a concern that Maternal and Child Health (MCH) should have been included in the newly mandated SRH Agency, as this would facilitate a more collaborative national SRH effort. Presently, the issues of MCH are covered within the Ministry of Health. 5. There is need for greater funding to continue the hard-won gains of the national HIV response. 6. There are competing priorities in Health and it is increasingly difficult for stakeholders to attend key HIV meetings/consultations.

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?: 25

5. What kind of support does the National HIV Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

Capacity-building: Yes

Coordination with other implementing partners: Yes

Information on priority needs: Yes

Procurement and distribution of medications or other supplies: No

Technical guidance: Yes

Other [write in]: Monitoring and evaluation,Financial support,Physical space for offices

: Yes

6. Has the country reviewed national policies and laws to determine which, if any, are incon-sistent with the National HIV Control policies?: Yes

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

IF YES, name and describe how the policies / laws were amended: The Public Health (Class 1 Notifiable Diseases) Order 2003 – This Order classified HIV and AIDS as a notifiable disease and as a communicable disease. Although HIV/AIDS is a communicable disease, it is not contagious . The Order was amended to only require mandatory notification of HIV/AIDS as a communicable disease solely for the purpose of surveillance. This is a significant achievement in efforts to reduce S&D.

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:: 1. The Law Reform (Age of Majority) Act – The age of majority for most purposes is 18, however for any medical treatment the consent of any minor who has attained age of 16 shall be as effective as it would be if he/she were 18, according to the Act. Therefore for adolescents under the age of 16 years, it becomes necessary for health care workers to obtain parental consent before providing medical care . It is important to note that the provision of contraception to minors under16 years is currently under review. a. Inconsistencies include: i. Providing access to HIV testing and treatment without parental consent exposes Health Care Workers (HCW) to liability. 2. Offences Against the Person Act (Buggery Law) – Criminalization of private, consensual same-sex sexual acts perpetuates stigma and discrimination against the most vulnerable populations and impedes their access to HIV/health information and services. 3. Offences Against the Person Act (Prohibit Prostitution) – makes the act of solicitation of women and girls for sex and the operation of brothels illegal in Jamaica. 4. Ministry of Labour & Social Security excludes PLHIV from the overseas farm workers programme as part of the general conditions of entry into the programme.

7. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the political support for the HIV programme in 2013?: 8

Since 2011, what have been key achievements in this area:: 1. The Minister of Health led the opening and presentation meeting of the integration of the National Family Planning Board and the National HIV/STI Programme. 2. The Minister of

Health in Parliament made statements that conveyed appreciation for work being done by the Ministry of Labour and Social Security in developing the National Workplace Policy on HIV and AIDS. 4. The Minister of Health has served on the PANCAP board where he has advocated for greater government resources for the sustainability of the National HIV/STI Programme (NHP). 5. The Minister of Labour and Social Security is spearheading the passage of the Occupational Health and Safety Act (OHSA) in Parliament. As it relates to HIV, the Act will protect employees who are HIV positive, and provide redress for PLHIV if they lose their jobs or are refused employment because of their HIV status. 6. The Minister of Health continues to advocate with Global Fund for a change in policy with regards to grant funding for countries with a high debt to GDP ratio such as Jamaica. 7. Senior Government Officials in the Ministry of Education re-enforce their commitment to the Health and Family Life Education (HFLE) in schools. 9. HFLE – Comprehensive and Legal Action to Support Student Health (CLASS_H) Pilot underway looking at referral system from the guidance counsellors to the Nurse at the health clinics. This system is only permitted if the parent has given permission. 10. Amendment of the Public Health Act to only requiring mandatory notification of HIV/AIDS as a communicable disease solely for the purpose of surveillance. This will go a long way in reducing S&D. 11. Establishment of the Inter-Ministerial Committee on Youth to look at barriers to access for services for youth. 12. There is periodic briefing of Cabinet members on HIV specific issues. The Ministries of Health and Justice jointly lead this initiative.

What challenges remain in this area:: 1. Financial constraints in the HIV response is an area to be addressed as the funding gap that remains is not within the current fiscal space of the government to finance. 2. The pace of legislative reform and policy adoption towards establishing an enabling environment is slow and the process is tedious. 3. The Ministry of Health remains the lead in the national HIV response, sometimes with little political buy-in from other sectors. 4. Many parliamentarians and other persons of influence do not prioritise HIV issues and are uncomfortable in discussing HIV-related issues. The attitudes of Parliamentarians towards HIV issues and concerns reflect, in part, the conservative views of most Jamaicans towards a range of sensitive social issues. 5. The responsiveness by government to civil society questions/inquires remains a challenge. To obtain the written response from the Minister of Health addressing the government’s position on the provision of ARVs required strong and lengthy advocacy from CS. 6. The pace of legislative reform and policy adoption to establish a more enabling environment is slow and the process is tedious. 7. Jamaica needs a comprehensive anti-discrimination policy and/or law, which affirm the human rights of all persons . 8. Stigma and discrimination remains a major issue for KPs and MARPs. 9. Offences Against the Person Act (Buggery Law) – Criminalization of private, consensual same-sex sexual acts perpetuates stigma and discrimination against the most vulnerable populations and impedes their access to HIV/health information and services.

A.III Human rights

1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable groups? Select yes if the policy specifies any of the following key populations and vulnerable groups:

People living with HIV: Yes

Men who have sex with men: No

Migrants/mobile populations: No

Orphans and other vulnerable children: Yes

People with disabilities: Yes

People who inject drugs: No

Prison inmates: No

Sex workers: No

Transgender people: No

Women and girls: Yes

Young women/young men: Yes

Other specific vulnerable subpopulations [write in]: Homeless

: Yes

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

IF YES to Question 1.1. or 1.2., briefly describe the content of the/laws:: 1. The Charter of Fundamental Rights and Freedoms (Constitutional Amendment) Act, 2011 – this Charter guarantees the right to life, liberty and security for persons and as citizens of a free and democratic society. It provides the right to freedom from discrimination on the ground of (i) being male or female; (ii) race, place of origin, social class, colour, religion or political opinions.

Briefly explain what mechanisms are in place to ensure these laws are implemented:: 1. Justice system (courts) 2. The Office of the Public Defender

Briefly comment on the degree to which they are currently implemented:: 1. Jamaica has active and vigilant human rights and activists interest groups. A challenge in accessing redress is the lengthy period of time the cases in the judicial system take to receive attention. 2. The Office of the Public Defender reports that between 2012 and 2013 no HIV-related complaints were filed.

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

IF YES, for which key populations and vulnerable groups?:

People living with HIV: No

Elderly persons: No

Men who have sex with men: Yes

Migrants/mobile populations: No

Orphans and other vulnerable children: Yes

People with disabilities: No

People who inject drugs: Yes

Prison inmates: Yes

Sex workers: Yes

Transgender people: Yes

Women and girls: No

Young women/young men: No

Other specific vulnerable populations [write in]::

: No

Briefly describe the content of these laws, regulations or policies:: 1. The Law Reform (Age of Majority) Act – For adolescents (including OVC) under the age of 16 years, it becomes necessary for health care workers to obtain parental consent before providing medical care . It is important to note that the provision of contraception to minors under 16 years is currently under review. 2. Offences Against the Person Act (Buggery Law) – Criminalization of anal sex (affects MSM, prison inmates and Transgender). 3. Offences Against the Person Act (Prohibit Prostitution) – makes the act of solicitation of women and girls for sex and the operation of brothels illegal in Jamaica.

Briefly comment on how they pose barriers:: 1. Barriers: a. The Law may not be the barrier but the cultural beliefs and societal norm fuelling S&D may be the driver. b. Creates a barrier to care for MSM and transgenders. c. Prohibits distribution of condoms in correctional facilities. d. MSM and SW are limited in accessing TCS. e. Minors are limited in accessing SRH services. f. Prohibits HCW in the provision of contraceptive methods and advice to minors. g. Limits public service announcements etc. – not able to do targeted prevention of anal sex through PSAs. h. The Laws prevent service providers from promoting safe anal sex publicly and approaching sex workers.

A.IV Prevention

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

IF YES, what key messages are explicitly promoted?:

Delay sexual debut: Yes

Engage in safe(r) sex: Yes

Fight against violence against women: Yes

Greater acceptance and involvement of people living with HIV: Yes

Greater involvement of men in reproductive health programmes: Yes

Know your HIV status: Yes

Males to get circumcised under medical supervision: No

Prevent mother-to-child transmission of HIV: Yes

Promote greater equality between men and women: No

Reduce the number of sexual partners: Yes

Use clean needles and syringes: No

Use condoms consistently: Yes

Other [write in]:: Adherence to T&C,Buy, carry and use condoms

: Yes

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

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

2.1. Is HIV education part of the curriculum in:

Primary schools?: Yes

Secondary schools?: Yes

Teacher training?: Yes

2.2. Does the strategy include

a) age-appropriate sexual and reproductive health elements?: Yes

b) gender-sensitive sexual and reproductive health elements?: Yes

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

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

Briefly describe the content of this policy or strategy:: All vulnerable populations are targeted with information, education, and behaviour change communication that promote prevention through risk-reduction, empowerment and treatment and care services. These strategies and policies include: 1. MSM and SW Strategies – seek to improve delivery of a comprehensive package of behaviour change communication based on prevention interventions targeting MSM and SW. 2. NSP – speaks to a comprehensive strategy utilising information technology being implemented particularly to reach hard to reach KPs. This includes the use of social media, websites, chat rooms and text messaging to promote risk reduction messages and support advocacy for increased access to services. 3. HFLE – Comprehensive and Legal Action to Support Student Health (CLASS_H) Pilot underway looking at providing students with information that will result in accessing needed health services through a referral system. This system operates from the guidance counsellors to the Nurse at the health clinics. This system is dependent on receiving the parents' permission.

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

People who inject drugs:

Men who have sex with men: Condom promotion,HIV testing and counseling,Reproductive health, including sexually transmitted infections prevention and treatment,Stigma and discrimination reduction,Targeted information on risk reduction and HIV education,Vulnerability reduction (e.g. income generation)

Sex workers: Condom promotion,HIV testing and counseling,Reproductive health, including sexually transmitted infections prevention and treatment,Stigma and discrimination reduction,Targeted information on risk reduction and HIV education,Vulnerability reduction (e.g. income generation)

Customers of sex workers: Condom promotion,HIV testing and counseling,Reproductive health, including sexually transmitted infections prevention and treatment,Stigma and discrimination reduction,Targeted information on risk reduction and HIV education,Vulnerability reduction (e.g. income generation)

Prison inmates: Condom promotion,HIV testing and counseling,Needle & syringe exchange,Reproductive health, including sexually transmitted infections prevention and treatment,Stigma and discrimination reduction,Targeted information on risk reduction and HIV education

Other populations [write in]:: OSY

: Condom promotion,HIV testing and counseling,Reproductive health, including sexually transmitted infections prevention and treatment,Stigma and discrimination reduction,Targeted information on risk reduction and HIV education,Vulnerability

reduction (e.g. income generation)

3.2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate policy efforts in support of HIV prevention in 2013?: 7

Since 2011, what have been key achievements in this area:: 1. Strategy of meeting Sex Workers and Clients at Club Sites has proven effective. 2. Government is fully committed to providing ARVs. 3. Increasing programme interventions are targeted at key populations. 4. Increased testing through campaign on proper condom usage. 5. Amendment to sexual offences Act to provide for gender equality 6. Development of MSM strategy.

What challenges remain in this area:: 1. Level and degree of implementation varies by parish, region and agency. 2. Socioeconomic and psychosocial support are needed 3. S&D continues to affect key populations accessing prevention services, which increases high-risk behaviours. 4. Funding remains a challenge as programmes and interventions desperately need scale-up. 5. Age of Majority limits minors from accessing much needed SRH services. 6. Offences Against the Person Act (Buggery Law) – Criminalization of anal sex (affects MSM, prison inmates and Transgender) and exposes the population to higher rates of S&D. 7. Political commitment in the face of potential outcry from religious and other significant groups in society could be greater.

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

IF YES, how were these specific needs determined?: 1. Monitoring and Evaluation activities through the use of reports, KAPB, surveys, epidemiological and surveillance data. 2. CS have conducted needs assessment to identify needs. 3. Based on vulnerabilities identified among target groups, through consultations and focus groups.

IF YES, what are these specific needs? : 1. Reduction in S&D. 2. Funding for HR programmes. 3. Ensuring successful evidence-based interventions are scaled-up. 4. Programme strategies that mitigate high-risk behaviours in the key populations and general population. 5. Improvement in social safety net. 6. Improving access to services by KP. 7. Condom skills and frequency of condom use. 8. Programmes to develop income generation skills. 9. Need for structural programme to support reduction in risk behaviour. 10. Scale-up testing to increase knowledge of HIV status.

4.1. To what extent has HIV prevention been implemented?

The majority of people in need have access to…:

Blood safety: Strongly agree

Condom promotion: Strongly agree

Economic support e.g. cash transfers: Agree

Harm reduction for people who inject drugs: N/A

HIV prevention for out-of-school young people: Strongly agree

HIV prevention in the workplace: Agree

HIV testing and counseling: Strongly agree

IEC on risk reduction: Agree

IEC on stigma and discrimination reduction: Agree

Prevention of mother-to-child transmission of HIV: Strongly agree

Prevention for people living with HIV: Agree

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

Risk reduction for intimate partners of key populations: Agree

Risk reduction for men who have sex with men: Agree

Risk reduction for sex workers: Strongly agree

Reduction of gender based violence: Agree

School-based HIV education for young people: Agree

Treatment as prevention: Agree

Universal precautions in health care settings: Strongly agree

Other [write in]:: drug users (Non-injecting), Homeless

: Agree

5. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in implementation of HIV prevention programmes in 2013?: 8

A.V Treatment, care and support

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

If YES, Briefly identify the elements and what has been prioritized:: 1. Health care services: Access to ART, provision of care services, access to support services, including adherence support through contact tracing, adherence counsellors, psychosocial support (psychologists and social workers). 2. Treatment for Prevention: HIV prevalence among MSM combined with the high risk of transmission associated with unprotected anal sex, support the implementation of ARV treatment for prevention among the PLHIV MSM population. 3. Prevention of MTCT Programme: In keeping with international standards and local issues, the programme will focus on prevention of unintended pregnancies among women living with HIV, prevention of HIV transmission from women living with HIV to their children and provision of treatment, care and support for women living with HIV and their children and families. 4. HIV Testing Programme: Testing of key populations and those most at risk will be scaled up. 5. Sexually Transmitted Infection Programme: Jamaica has achieved considerable success in reducing syphilis and other STIs through the decentralisation of syphilis testing, syndromic management of STIs and other measures. However, other STIs remain a significant problem. The position of Senior Medical Officer (Health) for STIs needs to be re-established so that there is on-going specialist leadership of the STI programme in Jamaica.

Briefly identify how HIV treatment, care and support services are being scaled-up?: 1. HIV Testing Programme: Testing of key populations and those most at risk will be scaled up. 2. Increased availability of ARVs. Adding more complements to reduce pill burden. 3. Implementing guidelines on treatment. 4. Including HIV test as routine test at all Hospitals. 5. Increasing the number of treatment sites across the country, especially in the more rural areas. 6. Increase HIV testing to identify PLHIV eligible for ART. 7. Widening the range of core services (HIV DR testing). 8. Increased access to psychosocial support.

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

The majority of people in need have access to…:

Antiretroviral therapy: Strongly agree

ART for TB patients: Agree

Cotrimoxazole prophylaxis in people living with HIV: Agree

Early infant diagnosis: Strongly agree

Economic support: Disagree

Family based care and support: Disagree

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

HIV testing and counselling for people with TB: Strongly agree

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

Nutritional care: Agree

Paediatric AIDS treatment: Strongly agree

Palliative care for children and adults Palliative care for children and adults: Disagree

Post-delivery ART provision to women: Strongly agree

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

Post-exposure prophylaxis for occupational exposures to HIV: Strongly agree

Psychosocial support for people living with HIV and their families: Strongly agree

Sexually transmitted infection management: Strongly agree

TB infection control in HIV treatment and care facilities: Agree

TB preventive therapy for people living with HIV: Disagree

TB screening for people living with HIV: Agree

Treatment of common HIV-related infections: Agree

Other [write in]:: Access to ARV in private pharmacies

: Agree

2. Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?: No

Please clarify which social and economic support is provided: Programme of Advancement Through Health and Education (PATH) is a conditional cash transfer (CCT) programme funded by the Government of Jamaica. There are 5 broad categories of beneficiaries, all of whom must satisfy the criteria of poverty to qualify for benefits. These are: • Children: from birth to completion of secondary education • Elderly: 60 years or over, and not in receipt of a pension • Persons with Disabilities • Pregnant and Lactating Women • Poor Adults 18-59 years There are no special provisions for PLHIV. All

beneficiaries are selected on the basis of one criterion only, that is, poverty. Information collected on applicants' health status is restricted to pregnancy and disability.

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

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

IF YES, for which commodities?: There is a national procurement mechanism as well as for supply management system for: 1. Medications - ARVs 2. Condoms 3. Lubricants 4. Substitutes 5. OI drugs

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care, and support programmes in 2013?: 7

Since 2011, what have been key achievements in this area:: 1. A number of Treatment, Care and Support systems have been strengthened through the standardisation of manuals and protocols. These include: a. New work on rapid test algorithm b. HIV Case-based Surveillance Manual c. Lost to follow up protocol d. Revision of PMTCT guidelines e. Revision of Treatment (Rx) manual f. Outreach testing protocol 2. Increasing options for new medications. 3. Jamaica has adopted the initiative for Eliminating Mother to Child Transmission of HIV and Congenital Syphilis. A multi-sectoral technical working group has been convened and pursues efforts to achieve this goal for Jamaica by 2015. 4. Private/Public partnerships in distributing ARVs creating greater accessibility for PLHIV. 5. Increased psychosocial support staff at treatment site throughout the country. 6. Preceptorship and mentoring of clinicians in management of HIV. 7. Regional trainings.

What challenges remain in this area:: 1. Recruitment and retention of staff. 2. S&D among health care providers is an area that is being addressed through capacity building and training sessions. 3. Retention throughout the continuum of care. 4. Treatment for Prevention: HIV prevalence among MSM combined with the high risk of transmission associated with unprotected anal sex support the implementation of ARV treatment for prevention among the PLHIV MSM population 6. HIV Testing Programme: reaching key populations and those most at risk remains a constant challenge. 7. Limited focus has been placed on the other STIs and as such it is essential for the STI programme to be evaluated in order to identify and address gaps within the programme. 8. Adherence is a growing challenge.

6. Does the country have a policy or strategy to address the needs of orphans and other vulnerable children?: Yes

6.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?: Yes

6.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children?: No

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2013?: 5

Since 2011, what have been key achievements in this area:: 1. Development of psychosocial support groups specific to OVC. 2. OVCs benefit from the implementation of the PHDP curriculum. 3. Availability of funding for SRs to provide services to OVC. 4. Strengthening of M&E for treatment services provided to the OVC population. 5. The achievements of Jamaica Perinatal Paediatric and Adolescent AIDS Programme (JAPPAIDS) in Treatment, Care and Support.

What challenges remain in this area:: 1. Limited national focus and investment provided to OVC over the last 8 years. 2. Absence of an OVC policy and/or strategy. 3. Scale-up of interventions for the OVC population. 4. Non-health related services for OVC. 5. Managing sexually active adolescents.

A.VI Monitoring and evaluation

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

Briefly describe any challenges in development or implementation:: 1. The recent integration of components with the NFPB that occurred in 2013. This merger requires a revised strategic plan and accompanying M&E plan to reflect a broader SRH agenda not just for HIV and this revision is still in progress. However, the previous M&E plan has not been abandoned and we continue to use it as a guide in the interim until a consolidated one is available. 2. M&E Plan developed in 2012 and needs to be updated to reflect changing scope. 3. Indicators need revision to relate to the wider programme of services covered by the integrated agency.

1.1. IF YES, years covered: Monitoring and Evaluation Plan 2012-2017

1.2. IF YES, have key partners aligned and harmonized their M&E requirements (including indi-cators) with the national M&E plan?: Yes, some partners

Briefly describe what the issues are:: Alignment has been achieved with key partners who are also SRs of the HIV Programme. However, there are partners with other areas of focus that require additional indicators to measure the impact of those programme activities.

2. Does the national Monitoring and Evaluation plan include?

A data collection strategy: Yes

IF YES, does it address::

Behavioural surveys: Yes

Evaluation / research studies: Yes

HIV Drug resistance surveillance: Yes

HIV surveillance: Yes

Routine programme monitoring: Yes

A data analysis strategy: Yes

A data dissemination and use strategy: Yes

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

Guidelines on tools for data collection: Yes

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

3.1. IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities?: 7-10

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

Briefly describe any obstacles:: 1. The current integration has split the M&E staff and operations. However, both components of the national response have M&E support. 2. Additional staffing is needed for optimal functioning and monitoring of the broadened programme areas.

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

In the Ministry of Health?: Yes

In the National HIV Commission (or equivalent)?: No

Elsewhere?: No

If elsewhere, please specify:

4.2. How many and what type of professional staff are working in the national M&E Unit?

POSITION [write in position titles]	Fulltime or Part-time?	Since when?
Biostatistician	Full-time	2006
Database Officer	Full-time	2005
M&E Officer	Full-time	2007
HIV/STI Information Officer	Full-time	2012
Data Entry Clerk	Full-time	2010
Director	Full-time	2006
Surveillance Officer	Full-time	1998
Database Manager	Full-time	2011

POSITION [write in position titles]	Fulltime or Part-time?	Since when?

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

Briefly describe the data-sharing mechanisms:: 1. There are standardized reports and reporting timelines 2. Officers monitor and collate reports that come in and try to track outstanding reports. 3. SRs submit monthly reports. 4. An annual Epidemic update is produced. 5. Survey findings and other forms of data are communicated through dissemination meetings. 6. Current publications and reports are uploaded to website.

What are the major challenges in this area:: 1. Timely submission of reports. 2. Communication plan for data sharing and timeframe for consistency.

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

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

IF YES, briefly describe the national database and who manages it.: 1. The M&E Unit at the MOH captures HIV-related data on diagnosis, treatment and clinical progression of all reported PLHIV. Data on prevention and enabling environment and Human rights activities are captured by the NFPB-SHA and provided to the MOH. 2. There is also a database that captures data on interventions done with other populations e.g. ANC, STI, tests done etc.

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

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

6.2. Is there a functional Health Information System?

At national level: No

At subnational level: No

IF YES, at what level(s)?:

7.1. Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?: Estimates of Current and Future Needs

7.2. Is HIV programme coverage being monitored?: Yes

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

(b) IF YES, is coverage monitored by population groups?: No

IF YES, for which population groups?: All epidemiological groups except the following: a. Clients of SW b. STI clinic attendees

Briefly explain how this information is used:: Information is used to increase our understanding of the epidemic, inform appropriate response, monitor the national programme, and determine the effectiveness of our national response.

(c) Is coverage monitored by geographical area?: Yes

IF YES, at which geographical levels (provincial, district, other)?: Data is reported by site, parish and regions.

Briefly explain how this information is used:: a. To provide feedback to sites. b. Guide prevention and outreach activities. c. For treatment planning and managing treatment programme.

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

9. How are M&E data used?

For programme improvement?: Yes

In developing / revising the national HIV response?: Yes

For resource allocation?: Yes

Other [write in]::

: No

Briefly provide specific examples of how M&E data are used, and the main challenges, if any:: 1. Annual surveillance reports. 2. Annual programme reports. 3. M&E meetings – MERG and TWGs. 4. To support the justification of interventions and to identify areas for strategic focus. 5. Main challenge is moving from research to practice.

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

At national level?: Yes

IF YES, what was the number trained:: 17

At subnational level?: Yes

IF YES, what was the number trained: 59

At service delivery level including civil society?: No

IF YES, how many?:

10.1. Were other M&E capacity-building activities conducted other than training?: Yes

IF YES, describe what types of activities: 1. Participation in mid-term and end of term evaluation of National HIV response in 3 other Caribbean Countries. 2. The National AIDS Spending Assessment (NASA) was conducted. 3. The Modes of Transmission Study was conducted. 4. Research in several areas especially treatment retention. 5. Completed end of term evaluation for Prevention and Enabling Environment. This evaluation utilised a learning by doing approach, and thereby sought to build capacity by using a local evaluation team to support the evaluation.

11. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the HIV-related monitoring and evaluation (M&E) in 2013?: 8

Since 2011, what have been key achievements in this area:: 1. Completion of the national level surveys – KAPB and Bio-behavioural surveillance of MSM and SW populations. 1. M&E Plan and Framework developed. 2. Consistent in soliciting reports and validation. 3. Ability to respond to requirements or requests for information. 4. The National AIDS Spending Assessment (NASA) was conducted. 5. The Modes of Transmission Study was conducted.

What challenges remain in this area:: 1. Establishing targets for all indicators to be included in the integrated M&E Plan. 2. Quality assurance at all levels. 3. Inadequate staffing.

B.I Civil Society involvement

1. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) has civil society contrib¬uted to strengthening the political commitment of top leaders and national strategy/policy formulations?: 3

Comments and examples:: 1. Civil Society (CS) was a key stakeholder along with government officials and international development agencies in drafting the National Strategic Plan (NSP) 2012-2017. CS contribution was formative in the planning and reviews of the NSP but CS had limited influence in setting the political agenda. 2. CS has worked closely with National HIV Programme (NHP) and holds membership on several technical working (TWG) groups including the Treatment and Care working group, Monitoring and Evaluation Reference Group (MERG), Enabling Environment and Human Rights (EEHR) and Prevention. 3. CS for the first time led the planning of the 2012 National Annual Retreat for the National HIV response. 4. Jamaica is unique in having a strong, vibrant and vocal civil society in the national response. The right to life and freedom of speech remains strong in our society and has enabled CS to work closely with government on aspects of the HIV response. However, CS falls short in its efforts to utilise strategic information, which is needed to garner political support and commitment. 5. Government work on policy does not include CS. Pressure is being applied from international disability rights organisations advocating for persons with disability to be included in policy level discussion to ensure access to services is on the agenda. 6. CS was engaged through consultations e.g. Global Fund proposal and PEPFAR submissions.

2. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) have civil society repre¬sentatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?: 3

Comments and examples:: 1. SC had strong presence in the NSP planning process but quite limited involvement in the budgeting process. Many CS representatives have not seen an NSP 2012-2017 budget. 2. A few CS entities were involved in consultations and working groups for setting of the budget for the NSP 2012-2017. 3. CS is involved in the planning component especially in the JCCM and NAC where input was provided on the NSP 2012-2017.

3. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) are the services provided by civil society in areas of HIV prevention, treatment, care and support included in:

a. The national HIV strategy?: 4

b. The national HIV budget?: 3

c. The national HIV reports?: 4

Comments and examples:: 1. The NSP 2012-2017 does not specify the role of stakeholders in detail, particularly as it relates to civil society and how they will contribute to the implementation of the national strategy. 2. CS is involved in the compilation of Monthly reports capturing data on programme implementation that feeds into the national reports such as GF, GARPR and

NCPI. These reports detail best practices and other contributions from civil society. 3. NHP captures only basic data from sub-recipients (SRs) that are funded by GF, PEPFAR and WB. CS that are not SRs have minimal involvement and input in the national HIV reports. Reports are more focused on the activities of government and less on CS. 4. Key populations (KP) are not well highlighted in the present national HIV policy but are captured in the NSP 2012-2017. 5. Services by CS as it relates to treatment care and support are components of the NSP and receive funding from the NHP programme and their report forms part of the national report.

4. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) is civil society included in the monitoring and evaluation (M&E) of the HIV response?

a. Developing the national M&E plan?: 3

b. Participating in the national M&E committee / working group responsible for coordination of M&E activities?: 3

c. Participate in using data for decision-making?: 3

Comments and examples:: 1. CSOs are longstanding members of the MERG. The MERG was restructured and presently has five (5) seats allocated to CS. CS participate in several workshops to assess the past M&E plan and to develop the current plan and were active in designing the workplan for implementing the MERG’s mandate. TWG meetings have been inconsistently held. 2. Reports and data are not systematically shared with CS. Capacity and opportunity of CS to use the data in decision-making is therefore limited. There is recommendation to increase data sharing and mentoring of CS by the national programme. 3. Overall, the M&E management of the response needs strengthening. Securing alliance with a strong M&E partner could be beneficial. 4. There are a few CSOs who are not involved in the national M&E process and have not been privy to the final documents or invited to dissemination meetings. 5. CS have benefited from and been involved in the M&E trainings. 6. National data is focused on key populations but not including disabilities.

5. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) is civil society representation in HIV efforts inclusive of diverse organizations (e.g. organisations and networks of people living with HIV, of sex workers, community based organisations , and faith-based organizations)?: 4

Comments and examples:: 1. Major efforts have been made by the NHP to be inclusive through organising and consulting to ensuring representation from all stakeholder groups. 2. Organisations representing MSM, SW, Youth, HIV positive mothers, and prison inmates are usually represented at planning meetings. Increased efforts are needed to engage and collaborate with FBOs in the response. 3. The quantity of representation should be one of several factors considered in organising around the response. Another factor to be considered is the quality and relevance of CS contribution to the national HIV response. 4. The JCCM membership offers diversity of organisations and networks of people infected and affected by HIV in Jamaica. 5. In Jamaica most CSOs in the national response represent one or more vulnerable group. Recently PLHIVs have branched off and formed even more specialised NGOs focused on FBO e.g. “Life, the Rebirth” and “Healing with Hope”. 6. There are few rural CSOs working with high-risk populations that are represented in the National HIV response. This is an area that remains weak and which more national attention is required to address the situation. 7. The disabled are not captured in the NSP as a vulnerable population but the disability community strongly advocate for disability to be reflected as a vulnerable group within the NSP.

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

a. Adequate financial support to implement its HIV activities?: 3

b. Adequate technical support to implement its HIV activities?: 3

Comments and examples:: 1. The National AIDS Spending Assessment (NASA) and is a good reference to speak to HIV resource allocation in Jamaica. Programme initiation activities are underway to undertake NASA 2014. 2. Civil society organisations have access to limited technical support. Technical support from government is also low. Most forms of support are from international organisations and/or external agencies. The technical support received is largely driven by funding requirements and not based on CS actual needs. 3. Grants are available via mechanisms such as World Learning, Health Policy Project, Global Fund and others. However, funds are not enough and usually only accessible by registered entities. 4. There are lower funding opportunities for programmes/interventions focused on psychosocial and parenting. 5. Limited access to technological resources, training and capacity building in the rural areas, which impacts programme implementation and delivery. 6. Jamaica’s adjusted rating by the World Bank giving the country upper middle status has redirected funds such as

GF away from the national HIV response. This impacts a number of areas including the participation of PLHIV as they have limited access to transportation to attend meetings, and threatens the sustainability of key programmes.

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

Prevention for key-populations:

People living with HIV: 51–75%

Men who have sex with men: 25-50%

People who inject drugs: <25%

Sex workers: 25-50%

Transgender people: <25%

Palliative care : <25%

Testing and Counselling: 25-50%

Know your Rights/ Legal services: 25-50%

Reduction of Stigma and Discrimination: 25-50%

Clinical services (ART/OI): <25%

Home-based care: <25%

Programmes for OVC: <25%

8. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts to increase civil society participation in 2013?: 9

Since 2011, what have been key achievements in this area:: 1. Greater involvement in the JCCM by CS. The revision of the JCCM Operations Manual speaks to greater involvement and more transparency. It also details the membership composition along with the seat allocations. 2. CS is experiencing increased partnership in the National Response and is being recognised for its work in the response. A good example of this was when CS was asked to coordinate the ‘best practices’ section of the GARPR, 2012. This provided a good medium in which CS was able to demonstrate examples of programmes that are making significant change by reducing risk-behaviour in the response. 3. Civil society is represented on the majority of steering committees and technical working groups in the HIV response. A few examples are: a. Justice for All steering group b. Stigma Index Steering Committee c. Gender Assessment d. National Review Meetings e. MERG 4. The integration of NFPB and NHP has sprung renewed life and cooperation between CS and the ‘new’ national team. 5. Revitalization of CSO forum which enabled strengthened participation in the national fora e.g. JCCM. National trainings were also held in proposal writing, research methods and advocacy, which were targeting increased funding opportunities for treatment and LGBT issues.

What challenges remain in this area:: 1. The lack of agreement between Regional Health Authorities and the National Programme on standardised operations creates challenges in programming and delivery. 2. CS are usually included in the report generation and data collection process but results and findings are not usually shared and disseminated to CS. 3. Lower levels of collaboration exist with CS outside the Kingston metropolitan area. Greater emphasis and collaboration is needed with CSOs that are not in Kingston. 4. Limited funding means agencies seek resources from government. While this increases collaboration in the national response, it is potentially crippling the advocacy function of CS. 5. There is growing concerns of some CSOs ability survive because of their limited access to funds that will enable them to remain vibrant and engaged in the response. 6. The collaboration between government and CS needs to be more strategic when working with specific populations

(MSM, OSY, CSW, etc.). 7. Increasing number of stigma and discrimination (S&D) reports are received about health care workers. This is quite disturbing given the increasing number of capacity building initiatives around S&D with health care workers. Obviously more needs to be done and use of disciplinary actions against these workers is necessary. 8. Very few CSOs work on policy related issues, which limits their full involvement and participation in policy negotiations. Capacity building and training are needed to support CS development in policy work.

B.II Political support and leadership

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

IF YES, describe some examples of when and how this has happened:: 1. CS who are JCCM members contribute in the design of Global Fund (GF) proposals. 2. As implementers, CS benefits from grants to implement programmatic interventions in the HIV response. 3. CS were involved in the 2013 Legal Review Process, which is a step towards Legal Reform. 4. CS has experienced, with exception of the Minister of Health, limited political support. Broader levels of discussions are needed with political leaders regarding S&D, and policy issues that are affecting HIV in the country. 5. Participation of CS is weighted heavily around programme implementation and less around programme design. 6. Government has been supportive of CS participation in the MARPS-TWG, EEHR-TWG, MERG- TWG as well as supporting key partnerships where communities contribute to development of workplans e.g. EEHR and Jamaica Network of Seropositives (JN+). 7. CS has participated in the development of the following policies/legislations: a. Workplace policy b. Occupational Health and Safety Act (draft)

B.III Human rights

1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable subpopulations? Circle yes if the policy specifies any of the following key populations:

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS:

People living with HIV: Yes

Men who have sex with men: No

Migrants/mobile populations: No

Orphans and other vulnerable children: Yes

People with disabilities: No

People who inject drugs: No

Prison inmates: No

Sex workers: No

Transgender people: No

Women and girls: Yes

Young women/young men: Yes

Other specific vulnerable subpopulations [write in]:: Non-injecting drug users, Homeless

: No

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

IF YES to Question 1.1 or 1.2, briefly describe the contents of these laws:: 1. Occupational Health and Safety Act (Draft) – will assist with workplace discrimination of PLHIV as well as providing legal support and redress to PLHIVs experiencing discrimination. 2. National Workplace Policy on HIV and AIDS (2011) – provides operational guidelines for workplaces in both the formal and informal sectors and helps to fight stigma and discrimination (S&D). 3. The Charter of Fundamental Rights and Freedoms (Constitutional Amendment) Act, 2011 – guarantees the right to life, liberty and security for persons and as citizens of a free and democratic society. It provides the right to freedom from discrimination on the ground of a. Being male or female b. Race c. Place of origin d. Social class e. Colour f. Religion or g. Political opinions. The Charter is not comprehensive and legislation is needed that looks broadly at the issue of non-discrimination and protection of human rights in Jamaica. 4. Staff Orders for the Public Service (Jamaica) – section 13.1 gives a policy statement that addresses the issues of discrimination within the public service. It states that employees shall be treated fairly and equitably without discrimination based on any of the following grounds : a. Age b. Gender c. National Origin d. Race e. Colour f. Religious Beliefs g. Political Affiliation h. Disability i. Sexual Orientation 5. Child Care and Protection Act – Children under 18 years.

Briefly explain what mechanisms are in place to ensure that these laws are implemented:: 1. Government Ministries and Public Service Commission (PSC) – Staff Orders. 2. Women and girls – Bureau of Women's Affairs. 3. OHSA – Ministry of Labour and Social Security. 4. Office of the Children's Advocate, Office of the Children Registry and Centre for the Investigation of Sexual Offences and Child Abuse.

Briefly comment on the degree to which they are currently implemented:: 1. CS are not aware of any case investigated by PSC or a government ministry. 2. BWA – Active agency in addressing these issues especially as they are an agency linked to the Office of the Prime Minister. 3. Charter of Fundamental Rights and Freedoms – The Office of the Public Defender reports that between 2012 and 2013 no HIV-related complaints were filed. 4. Offices of the Children's Advocate – actively involved in a number of investigations chiefly among them are sexual abuse of minors' cases. Advocate has been involved in policy discussions regarding discrimination. Involved in the discussion around access of minor to SRH services.

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

2.1. IF YES, for which sub-populations?

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS:

People living with HIV: Yes

Men who have sex with men: Yes

Migrants/mobile populations: No

Orphans and other vulnerable children: Yes

People with disabilities: No

People who inject drugs: No

Prison inmates: Yes

Sex workers: Yes

Transgender people: Yes

Women and girls: Yes

Young women/young men: Yes

Other specific vulnerable populations [write in]:: Adolescent, Non-injecting drug users, Homeless

: Yes

Briefly describe the content of these laws, regulations or policies:: 1. Offences Against the Person Act (Buggery Law) – Criminalises same sex intimacy and legitimatizes homophobia. Makes it illegal for anal sex either between two men or a man and a woman despite it being consensual. 2. Sexual Offences Act (Prohibit Prostitution) – Criminalises loitering for the purposes of sex work, and those who aid, abet and solicit the act of prostitution. 3. The Law Reform (Age of Majority) Act – Defines the age at which a child can access health services without parental consent.

Briefly comment on how they pose barriers:: Barriers: a. Drives the epidemic underground due in part to same sex activity being illegal and law enforcement uses the Buggery Act to prosecute gay people. b. Too many grey areas in providing treatment to minors and health care providers' fear of prosecution. The Act also limits young people under age 16 accessing SRH services while sexually active. c. Service providers engaging with sex workers in providing services are considered to be aiding and abetting.

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

Briefly describe the content of the policy, law or regulation and the populations included.: These pieces of legislation are not specific to HIV: 1. Domestic Violence Act– protects persons from violent acts or the threat of violence. The Act protects all person especially, girls and the mentally disabled. 2. National Policy for Gender Equality – Allows for gender to be definitively included in public policies, programmes, plans and projects. It will analyze gender processes to influence development plans and strategies. 3. The Charter of Fundamental Rights and Freedoms (Constitutional Amendment) Act, 2011 – speaks to non-discrimination based on Gender. 4. Jamaica is signatory to international conventions including Convention on the Elimination of all forms of Discrimination against Women (CEDAW), Convention on the Rights of the Child (CRC), Rights of Persons with Disabilities, International Convention on the Rights of Migrants Works, and the International Convention on the Elimination of Racial Discrimination.

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

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:: Promotion and protection of human rights is a key principle in the NSP 2012-2017. It states that all interventions should be guided by promotion, protection and respect for human rights and justice. Explicit activities to promote human rights are included for key populations. The EEHR component of the NSP develops its activities around protecting human rights, legal literacy and providing access to justice. This principle is echoed in the supporting strategies, such as the MSM and SW strategies.

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

IF YES, briefly describe this mechanism:: 1. National HIV related Discrimination, Reporting and Redress System (NHDRRS) – provides an avenue for PLHIV to report cases of HIV related discrimination. These cases are investigated and the necessary redress made. The system has been reviewed recently by EEHR in which findings and recommendations were made for strengthening. However, this this has not been disseminated to CS. The system housed at JN+. In 2012, 7 cases were reported against schools and churches. 2. Planning has started for the creation of an Observatory for Key Population. The responsible CSOs are JFLAG and CVC.

6. Does the country have a policy or strategy of free services for the following? Indicate if these services are provided free-of-charge to all people, to some people or not at all (circle "yes" or "no" as applicable).

Antiretroviral treatment:

Provided free-of-charge to all people in the country: Yes

Provided free-of-charge to some people in the country: No

Provided, but only at a cost: No

HIV prevention services:

Provided free-of-charge to all people in the country: Yes

Provided free-of-charge to some people in the country: No

Provided, but only at a cost: No

HIV-related care and support interventions:

Provided free-of-charge to all people in the country: Yes

Provided free-of-charge to some people in the country: No

Provided, but only at a cost: No

If applicable, which populations have been identified as priority, and for which services?: 1. MSM – Prevention interventions, condoms and lubricants, advocacy and treatment, care and support. 2. SW – Prevention interventions. 3. PLHIV – ARVs and support services. 4. OSY – Prevention interventions and empowerment. It is important to not that OSY age range is 15-24, which leaves out critical under 15 populations.

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

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

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

IF YES, Briefly describe the content of this policy/strategy and the populations included:: 1. National Health Policy Jamaica 2006–2015 - The Policy speaks to the population health and wellbeing by embracing general core values of equity, quality, confidentiality, and respect for all served by the health system. 2. NSP 2012-2017 – One of the guiding principles of the strategy is equity. This “ensures that no person be denied access to prevention knowledge, skills and services or treatment, care and support services on the basis of their real or perceived HIV status, sexual orientation, gender, age, disability, religious or other beliefs” . The vulnerable population mentioned includes MSM, SW, homeless, drug users, orphans, wards of the state, street and working children, persons living with disabilities, women and girls and prisoners.

8.1. IF YES, does this policy/strategy include different types of approaches to ensure equal access for different key populations and/or other vulnerable sub-populations?: Yes

IF YES, briefly explain the different types of approaches to ensure equal access for different populations:: 1. Outreach to vulnerable populations 2. Empowerment activities 3. Structural determinants addressed 4. VCT – referral and care 5. Using a gender mainstreaming approach 6. Peer link approach

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

IF YES, briefly describe the content of the policy or law:: 1. Workplace Policy on HIV and AIDS (except for Overseas Employment Programme); endorses the International Labour Organization (ILO) code of practice for HIV and AIDS and the world of work in stating that employees or potential employees should not be screened for HIV as a condition of employment

or pre-employment. It should be noted that there is no legislation prohibiting screening for HIV for employment reasons and a few employers continue this practice. 2. OSH Act (draft) – The Act strictly follows the ILO principles and cover similar areas as the Workplace Policy on HIV and AIDS.

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

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

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

IF YES on any of the above questions, describe some examples:: 1. The office of the Public Defender. 2. Independent Jamaica Council for Human Rights. 3. Jamaicans for Justice. 4. The recently established EEHR-TWG will collaborate with M&E to hone in on suitable indicators. 5. National HIV related Discrimination, Reporting and Redress System (NHDRRS).

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

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

b. Programmes for members of the judiciary and law enforcement46 on HIV and human rights issues that may come up in the context of their work?: Yes

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

a. Legal aid systems for HIV casework: No

b. Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV: No

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

IF YES, what types of programmes?:

Programmes for health care workers: Yes

Programmes for the media: Yes

Programmes in the work place: Yes

Other [write in]:: Management of HIV in education settings,Public education (general population),Media campaign, Women’s groups, Women’s groups, Prisons, Church

: Yes

14. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2013?: 5

Since 2011, what have been key achievements in this area:: 1. Cabinet’s and Parliament’s acceptance of the National Workplace Policy in 2012. 2. Draft Occupational Health and Safety Act is in the final stages of completion before submission to Cabinet has stated by the Minister of Labour and Social Security. 3. Increased awareness of human rights through media,

workshops, among other interventions. 4. Increased recognition of the gaps in the laws largely because of donor funded studies on confidentiality laws; capacity assessment of legal aid services for PLHIVs in Jamaica. 5. Improvements in capturing gender disaggregated data. 6. Improving gender mainstreaming in policies, strategies and programmes.

What challenges remain in this area:: 1. Very slow movement where government approval is required for policies and laws to be established, for example, the OHSA Act has been on the table for 18 years. 2. Funding remains a major area of concern in the sustainability of the HIV response. 3. Absence of a rigorous monitoring framework for EEHR/Policy implementation. 4. Absence of an anti-discrimination policy and law. 5. Some of Jamaica's culture and religious perspectives sometimes hinder implementation of HIV programmes. 6. Weak National HIV Discrimination, Reporting and Redress System for PLHIV. 7. Strategies are needed to delinking HIV-related issues from the perception of gay agenda. 8. Some church-based negative perception with regards to the view that human rights equal gay rights. 9. Human rights issues for PLHIV are mostly discussed in specific meetings; it is not widely discussed in the society. 10. Some employers continue compulsory testing for purposes of exclusion from employment and work processes.

15. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the effort to implement human rights related policies, laws and regulations in 2013?: 5

Since 2011, what have been key achievements in this area:: 1. There is increase focus on HR issues for general and KP as noted in the formation of the EEHR TWG. 2. Increased public debate on human Rights (HR) and key population (KP). 3. Increased engagement of Faith Based Organizations (FBOs) 4. Current policy and legal reviews on the Child Care and Protection Act; Adolescent access to VCT; sexual and reproductive health (SRH) for minors. 5. Increased collaboration between CS and National Family Planning Board (NFPB), the agency that is mandated to integrate the National HIV Programme.

What challenges remain in this area:: 1. The reluctance of government to develop and enforce sanctions on employees, for example, health care providers who breach confidentiality. 2. Low levels of government support. 3. Greater levels of protection needed to protect PLHIV in their communities. 4. High levels of compulsory testing for employment. 5. Jamaica is unable to definitively describe the epidemic among adolescence.

B.IV Prevention

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

IF YES, how were these specific needs determined?: 1. Assessment of existing prevention strategies with a view to strengthening programmes and interventions. 2. Focus on using strategic information from key studies such as the Knowledge Attitude, Practices and Behaviour (KAPB) and Modes of Transmission (MOT). The MOT research identified new points of prevention intervention. 3. Repeated consultation with CS, IDA and other key partners in the HIV response. 4. Lessons learnt from evaluation studies and CS good practices from the last strategic period.

IF YES, what are these specific needs? : 1. Reducing high-risk behaviour among MSM. 2. KP focused interventions including out of school youth, injecting drug users and women. 3. Education by expanding sexual and reproductive health prevention of sexual transmitted infection, condom access and improving the numbers of people getting a HIV test. 4. Economic empowerment through skills improvement. 5. Adolescence (boys & girls) and youth. Glaring gap within the programme implementation.

1.1 To what extent has HIV prevention been implemented?

The majority of people in need have access to…:

Blood safety: Strongly agree

Condom promotion: Strongly agree

Harm reduction for people who inject drugs: N/A

HIV prevention for out-of-school young people: Strongly disagree

HIV prevention in the workplace: Agree

HIV testing and counseling: Agree

IEC on risk reduction: Agree

IEC on stigma and discrimination reduction: Agree

Prevention of mother-to-child transmission of HIV: Strongly agree

Prevention for people living with HIV: Disagree

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

Risk reduction for intimate partners of key populations: Disagree

Risk reduction for men who have sex with men: Disagree

Risk reduction for sex workers: Agree

School-based HIV education for young people: Disagree

Universal precautions in health care settings: Agree

Other [write in]:: Homeless

: Strongly agree

2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in the implementation of HIV prevention programmes in 2013?: 7

Since 2011, what have been key achievements in this area:: 1. Scale up of engagement with CBOs, NGOs, although this area remains weak. 2. Development of MSM and SW strategies. 3. Technical working group convened to harmonise MSM efforts and interventions through out the response. 4. Scale-up of outreach-based interventions is commendable. 5. CS participation in Gender Equality Trainings through the UN Women Project/NHP: a. Training of trainer (2011). b. University of the West Indies Mona course – Gender, Sexual and Reproductive Health and HIV Training at the (2012). 6. Increase distribution of condoms in particular circles promoting safer sex awareness programmes.

What challenges remain in this area:: 1. Absence of a policy for minors relating to sexual and reproductive health. 2. Reaching larger numbers of key populations. HIV prevention activities are still not sufficiently reaching MSM as a key population, while the transgender community is not reached at all. 3. Finalising and giving teeth to the MSM and SW strategies and obtain full support and buy-in from CS. 4. Rural communities are severely underserved and a definitive strategic direction is needed to create rural-base service points. 5. More strategic collaboration with CS groups is needed for results to be realised in KP. 6. Funding is of great concern. 7. Widen the vulnerable population category with the HIV response to include persons with disabilities. 8. Jamaica has a mixed-epidemic but programmes are designed to address a concentrated epidemic.

B.V Treatment, care and support

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

IF YES, Briefly identify the elements and what has been prioritized:: 1. Emphasis on treatment but not so much on care and support. 2. Development TCS protocols. 3. The model for treatment and care regarding testing and treatment has been identified. Universal testing and retention in care has been prioritised. 4. Identification has been done of key activities but implementation remains a challenge. The monitoring of the adherence programme is limited largely to pill counts.

Briefly identify how HIV treatment, care and support services are being scaled-up?: 1. Increased number of social workers and adherence counsellors. 2. Increased efforts for treatment literacy for PLHIVs. 3. Provider initiated testing and counselling has been introduced in all public hospitals (testing on admission) through the Regional Health Authorities. However, uptake still remains low. 4. All primary level care facilities above level 2 offers VCT.

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

The majority of people in need have access to…:

Antiretroviral therapy: Strongly agree

ART for TB patients: Agree

Cotrimoxazole prophylaxis in people living with HIV: Strongly agree

Early infant diagnosis: Strongly agree

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

HIV testing and counselling for people with TB: Agree

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

Nutritional care: Agree

Paediatric AIDS treatment: Strongly agree

Post-delivery ART provision to women: Agree

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

Post-exposure prophylaxis for occupational exposures to HIV: Strongly agree

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

Sexually transmitted infection management: Agree

TB infection control in HIV treatment and care facilities: Strongly disagree

TB preventive therapy for people living with HIV: Strongly disagree

TB screening for people living with HIV: Disagree

Treatment of common HIV-related infections: Disagree

Other [write in]::

:

1.2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2013?: 7

Since 2011, what have been key achievements in this area:: 1. The Country provides of ARVs free of cost, which are available widely through government facilities and participating private pharmacies. 2. Strong PMTCT programme – PMTCT program is making positive achievements in the Mother to Child Transmission Elimination Initiative. 3. New treatment protocols developed. 4. Increased testing through outreach and PITC. 5. Great improvements in the procurement of medication by Ministry of Health, which reduces ARV storage. 6. New ART medication regime available.

What challenges remain in this area:: 1. Although ARVs are free, medications for the associated conditions are at a cost, such as Opportunistic Infections (OIs). 2. Poor psychosocial support and counselling. 3. Limited TB co-infection analysis among PLHIV. 4. Greater attention needed around nutrition for PLHIV. 5. Comprehensive OVC programme needed in the HIV response. 6. Treatment retention is low with high rates of loss to follow-up. 7. Young PLHIVs are not adhering nor is there an established mentoring program for this vulnerable population. As a result there are increasing AIDS-related deaths of persons less than 25 years. 8. Adherence programme does not cater for adolescence and youth PLHIVs. 9. More interventions are needed with HCW as the numbers of S&D complaints from PLHIVs are increasing, particularly among those receiving anal care, and hormonal treatment. 10. Confidentiality training needed for all employees at health facilities not just nurses and doctors. 11. The monitoring of the adherence programme is limited largely to pill counts. 12. Getting data from the private sector remains a challenge. 13. A perceived unexplained increase in the number of HIV-related deaths.

2. Does the country have a policy or strategy to address the needs of orphans and other vulnerable children?: Yes

2.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?: Yes

2.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children?: Yes

3. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2013?: 2

Since 2011, what have been key achievements in this area:: The area of OVC has not been prioritised and limited achievements can be highlighted at this time. 1. Localised programme interventions assisting families with OVCs in the western part of the country.

What challenges remain in this area:: 1. OVC has received limited attention. They are included in the NSP 2012-2017, but have received little attention by CS. 2. Data remains a challenge and at this time the magnitude of the OVC situation in the country cannot be determined. 3. Limited access to social safety networks. 4. No funding appears to be available and where funding is available, there is no strategic direction. 5. Minimal inter-ministerial cooperation around the issue of OVCs. 6. Minimal government leadership is directed towards OVCs.