Jamaica Global AIDS Monitoring Report 2019

THE GLOBAL AIDS MONITORING REPORT

OF

JAMAICA 2018

……	……..
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Executed and submitted to the United Nations Programme on HIV and AIDS 1st day of April, 2019

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LIST OF ACRONYMS

AC	Adherence Counsellors
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behaviour Change Communication
CD4	Cluster of Differentiation
CBO	Community-based Organization
CCM	Country Coordinating Mechanism
CF	Community Facilitators
CM	Case Manager
CRH	Cornwall Regional Hospital
CSO	Civil Society Organization
CVCC	Caribbean Vulnerable Communities Coalition
DHIS2	District Health Information System 2
EEHR	Enabling Environment and Human Rights
EMTCT	Elimination of Mother-To-Child Transmission
FAACC	Fort Augusta Adult Correctional Centre
FHU	Family Health Unit
FSW	Female Sex Worker
GIPA	Greater Involvement of Persons with HIV/AIDS
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOJ	Government of Jamaica
HARC	Horizon Adult Remand Centre
HATS	HIV/AIDS Tracking System
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HP+	Health Policy Plus
HSTU	HIV/STI/Tb Unit
ITECH	International Training and Education Center for HIV

JADS	Jamaica Anti-Discrimination System
JaPPAIDS	Jamaica Paediatric, Perinatal and Adolescent HIV/AIDS Programme
JASL	Jamaica AIDS Support for Life
JCW+	Jamaica Community of Positive Women
JFJ	Jamaicans for Justice
JN+	Jamaica Network for Seropositives
JSC	Joint Select Committee
JYAN	Jamaica Youth Advocacy Network
KAPB	Knowledge, Attitude, Practices and Behaviour
KP	Key population
LFA	Local Funding Agent
MLSS	Ministry of Labour and Social Security
MOE	Ministry of Education
MoFPS	Ministry of Finance and Public Service
MOH	Ministry of Health
MOJ	Ministry of Justice
MSM	Men who have Sex with Men
NBACC	New Broughton Adult Correctional Centre
NERHA	North East Regional Health Authority
NFPB	National Family Planning Board
NGO	Non-Government Organization
NHF	National Health Fund
NHP	National HIV/STI Programme
NISP	National Integrated Strategic Plan
NPHL	National Public Health Laboratory
NSU	National Surveillance Unit
OSH	Occupational Safety and Health
PAHO	Pan American Health Organization
PEPFAR	President’s Emergency Plan for AIDS Relief
PCR	Polymer Chain Reaction
PCPM	Programme Coordination, Planning and Management
PDSA	Plan Do Study Act

PHDP	Positive Health Dignity and Prevention
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV/AIDS
PLACE	Priority for AIDS control Efforts
PMTCT	Prevention of Mother-To-Child Transmission
PN	Patient Navigators
PSIS	Prevention Services Information System
RFACC	Richmond Farm Adult Correctional Centre
RHA	Regional Health Authority
S&D	Stigma & Discrimination
SERHA	South East Regional Health Authority
SI	Strategic Information
STI	Sexually Transmitted Infection
SRH	Sexual and Reproductive Health
ST. CACC	St. Catherine Adult Correctional Centre
SWIT	Sex Worker Implementation Tool
Tb	Tuberculosis
TCS	Treatment, Care and Support
TFACC	Tamarind Farm Adult Correctional Centre
TG	Transgender/Persons of Trans-experience
TOT	Training of Trainers
TransIT	Trans Implementation Tool
TRAT	Treatment Readiness Assessment Tool
TSACC	Tower Street Adult Correctional Centre
TSIS	Treatment Site Information System
TWG	Technical Working Group
UBRAF	UNAIDS United Budget, Results and Accountability Framework
UCSF	University of California, San Francisco
UIC	Unique Identifier Code
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNJT	United Nations Joint Team

USAID	United States Agency for International Development
VBI	Venuebased Intervention
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
WRHA	Western Regional Health Authority
YATWG	Youth and Adolescent Technical Working Group

TRIBUTE

This section presents a tribute to those lost to AIDS in memoriam. As responders to the HIV epidemic in Jamaica, every day we keep fighting and moving forward. To honour those who have gone and for those who live on, we fight, advocate and create innovative interventions. We won't rest until AIDS is defeated!

International AIDS Conference, Amsterdam, July 2018. Jamaica Community of Positive Women (JCW+) booth.

1 Acknowledgement

This GAM report, covers the 2018 period and where 2018 data was not available up to the time of the report preparation, 2017 data was used. The Ministry wishes to acknowledge the support of all partners to combat HIV transmission; including international development partners such as the Global Fund to fight AIDS, Tuberculosis and Malaria, the United States President's Emergency Fund for AIDS Relief and the United Nations Programme on HIV and AIDS. The Ministry also acknowledges the impactful role of Civil Society, PLHIV Networks and all Government Ministries in the progress achieved in the response.

The preparation of this report was made possible through the leadership of the National Family Planning Board, represented by Tazhmoye Crawford and a diverse GAM Steering Committee; National Family Planning Board, also represented by Lovette Byfield, Andre Black, Marvin Josephs, Devon Gabourel and Claudette McLeish; Jamaica Network of Seropositive represented by Ricky Pascoe; Ministry of Health represented by Tanesha Hickman and Sasha Martin; Ministry of Labour and Social Security represented by Marlon Mahon; Ministry of Foreign Affairs and Foreign Trade represented by Dimitry Robertson; Ministry of Education Youth and Information represented by Anna-Kay Magnus; Civil Society represented by Xavier Biggs; The Attorney General's Chamber represented by Scott Mullings; UNAIDS represented by Erva-Jean Stevens; PAHO represented by Valeska Stempluick; and UNICEF represented by Novia Condell; Consultant Suzanne Robinson-Davis.

The efforts by programme leads to provide and review data and information is greatly appreciated.

The NFPB wishes to thank UNAIDS and PAHO for providing financial and technical support for this process.

I. Introduction

Jamaica is an island located in the north-west Caribbean, surrounded by the Caribbean Sea. With a total land area of 10,831 square kilometres, it is approximately 235 kilometres long and 82 kilometres wide, making Jamaica the largest English-speaking Caribbean country. The closest countries to Jamaica are Cuba - 145 kilometres north, and Haiti - 177 kilometres west. Located 901 kilometres below the south-eastern part of the United States, Florida is the closest U.S. state to Jamaica.

The country is geographically divided into 14 parishes, with two cities - Montego Bay, in the parish of St. James and Kingston, located in the north-west south-east end of the island, respectively. A third municipality, Portmore, is located in the parish of St. Catherine, to the west of Kingston.

Jamaica estimated its population at 2,728,900 (STATIN, 2018) with the majority of the population residing in the capital city, Kingston, and among other of its larger urban towns. Similar to the rest of world, Jamaica is experiencing steady decline in population growth. In 2017, the only age group that showed growth was among the 15-65 age group, indicative of a growing labour force (STATIN, 2018). Jamaica's2017 population broad age group distribution and percentage reflect the following:0-4 years (6.7%); 5-14 years (15.2%); 15-64 years (69.3%) and 65 years & over (8.8%) (STATIN, 2018).

Jamaica remains steadfast in its fight against HIV and AIDS. In 2016, at the United Nations General Assembly, member countries including Jamaica, requested that countries "provide to the General Assembly, within its annual reviews, an annual report on progress achieved in realizing the commitments made in the present Declaration and request continued support from the Joint United Nations Programme on HIV/AIDS (UNAIDS) to assist countries to report annually on the AIDS response" (UNGA, 2016). Jamaica is committed to the high-level declaration and consistently provides annual reports, like the Global AIDS Monitoring (GAM) report with the assistance of UNAIDS, civil society and other partners.

1.1 The national response

Jamaica has been an early responder to the HIV epidemic. For 36 years, medical and public health practitioners have responded to, arguably, a sudden yet vicious disease. Furthermore, as a country, Jamaica has for 31 years responded through integrated national policies, leading the charge to fight HIV and AIDS and to protect, treat and care for people living with HIV. As the country creates strategies for 2019, Jamaica is in a much more formidable position, has learned many lessons, empowered community leaders, forged powerful partnerships and united a mighty force of stakeholders to advance the 2030 Agenda for Sustainable Development through the 90-90-90 goals towards ending the AIDS epidemic.

HIV priorities have been integrated at the highest levels of government policies, including through the National Development Plan - Vision 2030 Jamaica. This is visible through the increased budgetary allotments provided to support the HIV/STI national strategies. The fruit of this can be seen, for example, with countries throughout the English-speaking Caribbean achieving the highest proportion of people living with HIV who know their status. Embedded in this report is further documentary evidence of Jamaica's commitment over the past year to move closer to achieving our national targets.

Sustained and committed partnership lies at the heart of Jamaica's achievements. Although there is much further to grow and more to learn, the country, through treatment and prevention, made striking in-roads in supporting and protecting our people. Scaling up the number of people on antiretroviral therapy, retained in care, while achieving viral suppression remains a priority. In 2018, Jamaica achieved sustained supply of ARV medication with no stock outs. This helped to ensure optimal access for people living with HIV to remain adherent to their medication schedules and regimen. Significantly, the National Health Fund (NHF) assumed the management of government pharmacies in 2017, providing for national standardization, as well as improved tracking and dispensing of ARV medication.

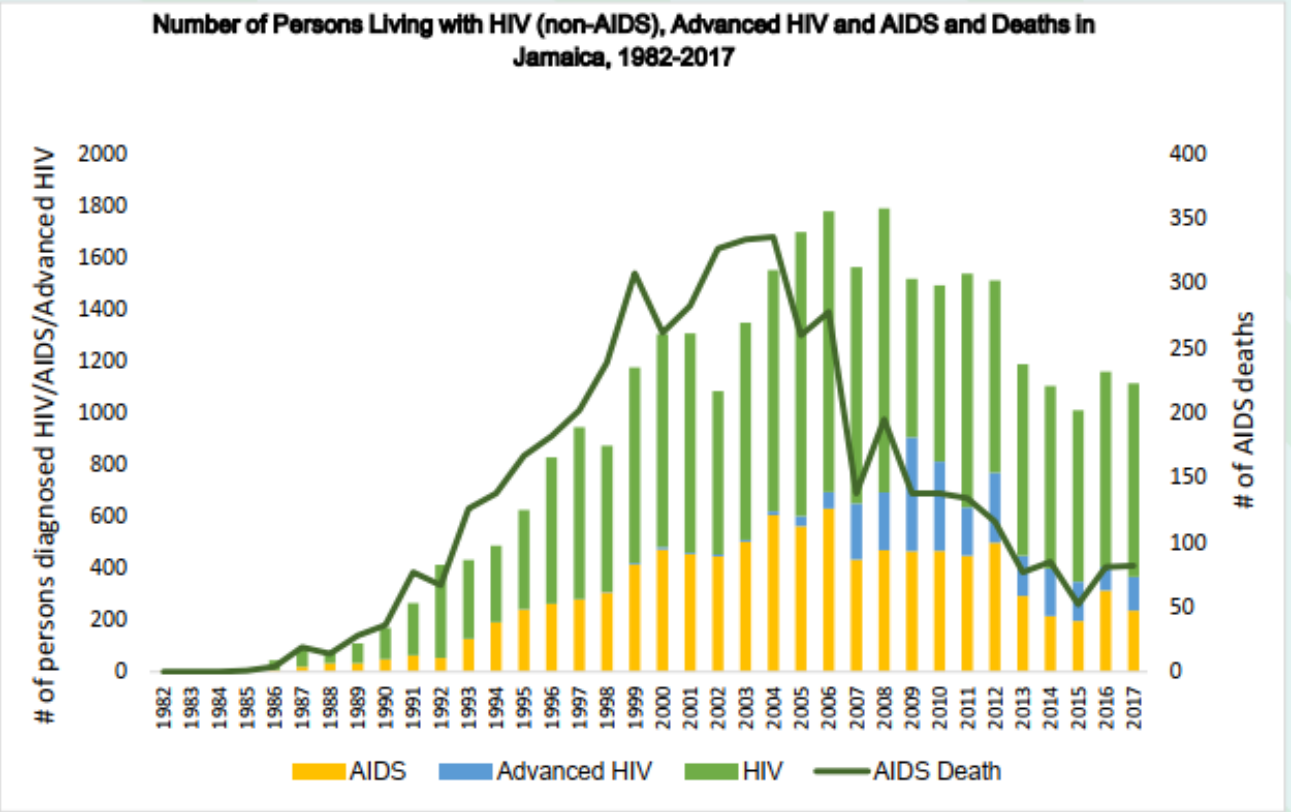
Findings from the *Mid-term Evaluation of the National Integrated Strategic Plan for Sexual and Reproductive Health and HIV, 2014-2017*, have prompted targeted interventions among health care providers. Implemented through the Ministry of Health, the National Family Planning Board and civil society organizations, key SRH and HIV workshops and trainings among health workers have been undertaken.

By the end of 2018, the Fast Track City Project gained momentum. The Mayor of the city of Kingston committed to lead, with the Ministry of Health the roll out of initiatives to reduce HIV transmission in Kingston and St Andrew. Ending AIDS in Jamaica will require rapid control in Kingston and St Andrew as data shows the city has over 27% of PLHIV, the highest HIV new case rate, highest seroprevalence in STI attendees and second highest HIV death rate. Boldly, Kingston and St. Andrew Municipal Corporation, under the leadership of the Mayor of Kingston, has partnered with the MOH, UNAIDS and IAPAC to combat stigma and discrimination, increase the number of persons who are aware of their HIV status and receiving ARV treatment, and to advance the welfare and healthcare of those who are affected by HIV and AIDS.

1.2 Jamaica's HIV Epidemic

Jamaica has a HIV prevalence of 1.8%. In 2017, Jamaica experienced 1,197 new HIV diagnoses with males accounting for the higher proportion of new cases (males: 621, females: 576). However, nestled within both a generalized and concentrated HIV epidemic, the country experiences prevalence as high as 29.8% within the MSM and 51% in the TGW populations. In 2017, an estimated 34,000 people were living with HIV in Jamaica (UNAIDS Spectrum model, 2017). Of that number 22% remain unaware of their HIV status. Based on Jamaica's Public Health Order, HIV is a class 1 notifiable disease, requiring mandatory reporting. Between 1982 to 2017, 36,553 HIV diagnoses have been received by the Ministry of Health, of which, 10,127 (27.7%) are deceased.

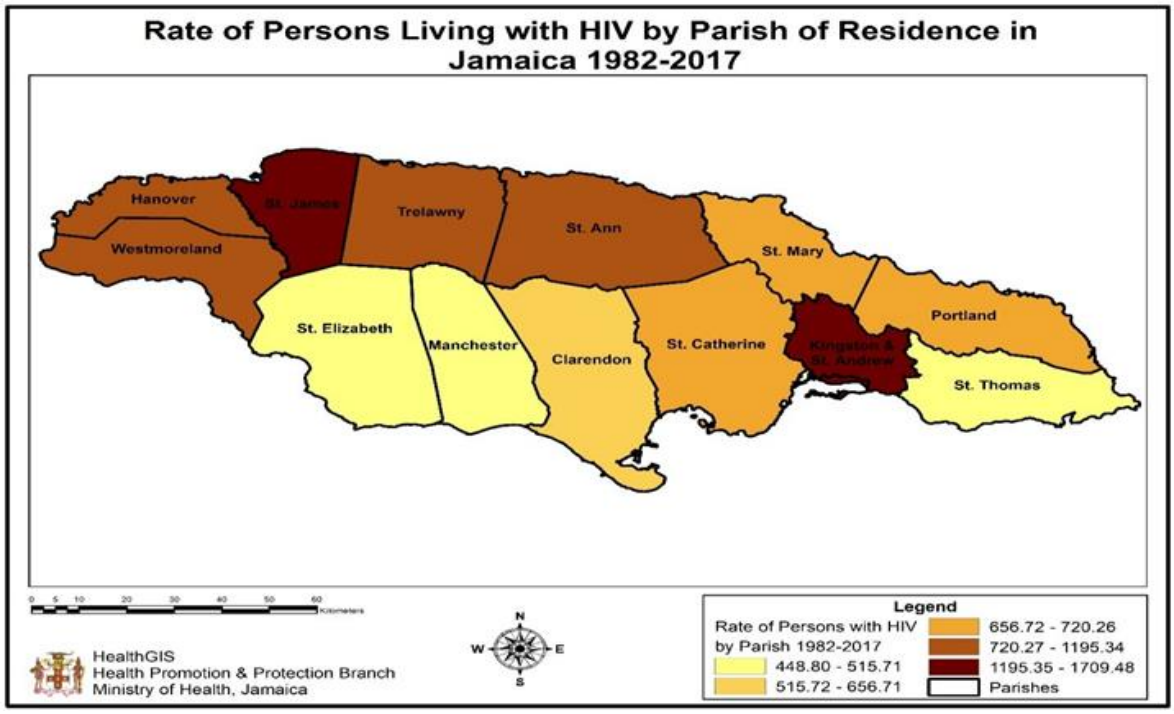
Figure 1: Persons Living with HIV (non-AIDS), Advanced HIV and AIDS and Deaths, Jamaica, 1982-2017



Source: HIV Epidemiological Report, 2017

Although the HIV epidemic in Jamaica is marked by steady increase in new diagnoses, the height of the epidemic was between 2006 and 2008. Figure 1 shows that although there were significant declines in 2015, steady increase occurred in 2016. Encouragingly, 2017 shows a relative levelling off the epidemic, possibly signally an opportunity to turn the tide, by further reducing new HIV infections.

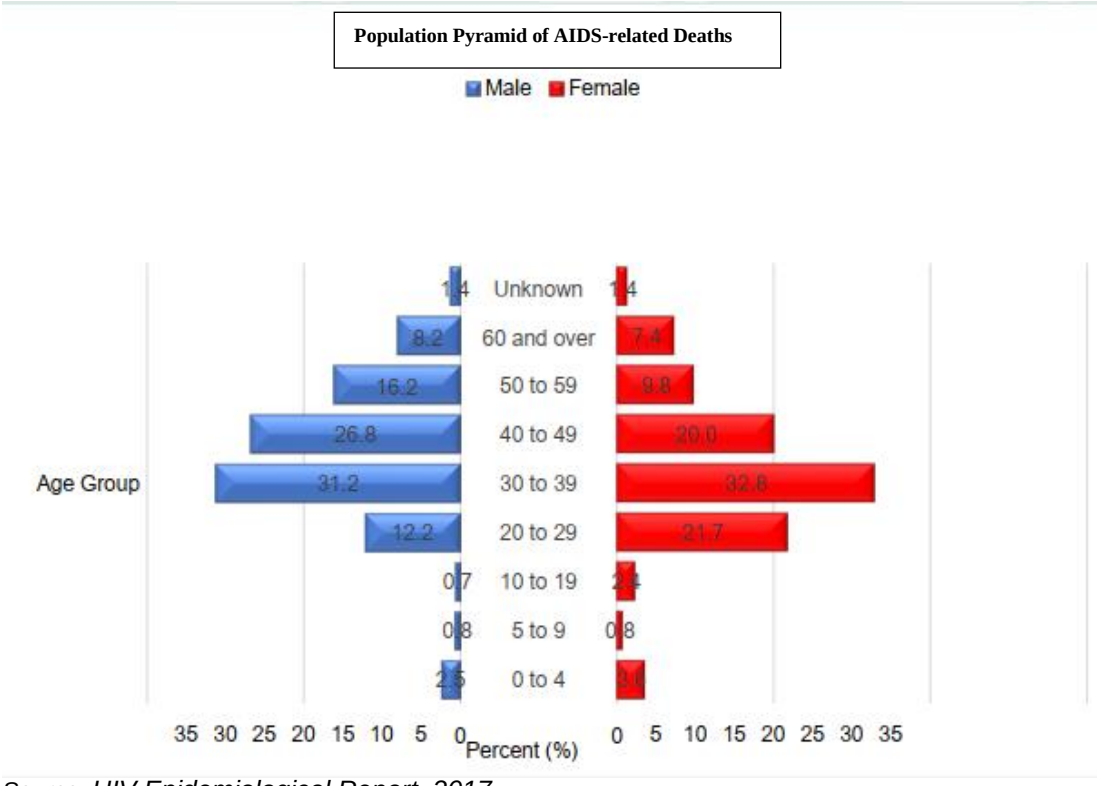
Figure 2: Rate of persons living with HIV/AIDS in Jamaica by Parish of residence (1982-2017)



Source: HIV Epidemiological Report, 2017

Although Jamaica's HIV epidemic traverses the width of the island, there are noticeable areas of concentration. Tourism-centred urban areas record the highest numbers of new diagnoses. Kingston and St. Andrew experienced the highest number of new HIV diagnoses, with Manchester experiencing the least cases in 2017. In Figure 2, the darker shaded areas display the highest rates of diagnoses and rate of PLHIV residences by parish.

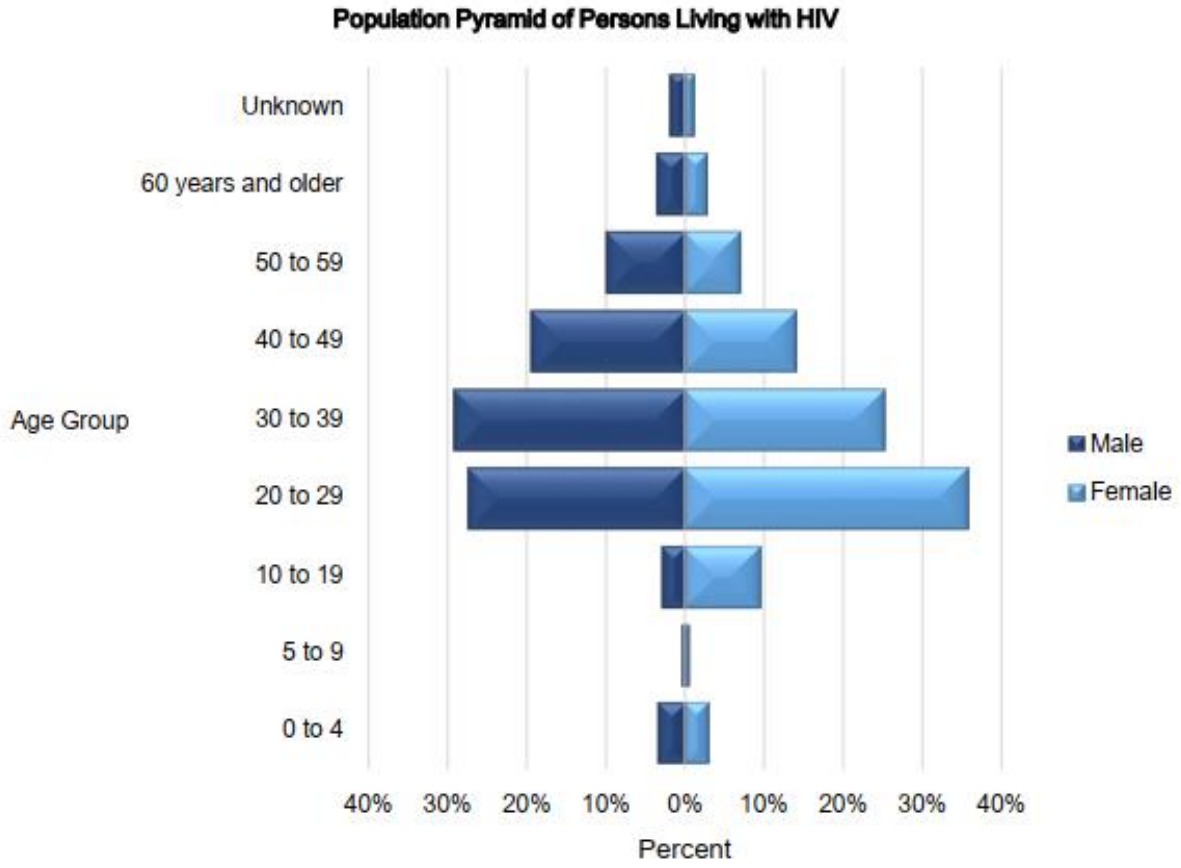
Figure 3: HIV/AIDS related deaths in Jamaica by sex and current age (1982-2017)



Source: HIV Epidemiological Report, 2017

However, the National Programme experienced many gains, among which were declinesin new HIV diagnoses by 41% with 8% fewer late diagnoses from 2016. Additionally, in 2017, there were fewer AIDS deaths, a 10% decline. Interestingly, Figure 3 shows that the majority of PLHIV deaths that occurred in males were between the ages of 40 to 49 years, whereas for females, the majority of deaths were between ages 30 to 39 years.

Figure 4: People living with HIV/AIDS by Sex and Current Age Group, Jamaica (1982-2017)



Source: HIV Epidemiological Report, 2017

At the end of 2017, an accumulated 26,426 people were diagnosed with HIV in Jamaica. Of that number, people aged 20-39 years accounted for the largest number irrespective of gender and age groups. Of interest, in Figure 4, more females living with HIV are found in the age group 20-29 years, while males dominate the 30-39 age group. The 0-4 age group and the 5-9 age group accounted for 3% and 1% respectively of the HIV diagnoses in 2017.

Jamaica uses sentinel survey as a national proxy for incidence. According to Table 1, there was a slight increase among antenatal clinic attendees from 0.8% in 2016 to 0.9%. Only three parishes experienced increase in seroprevalence. Among the parishes were Kingston and St. Andrew, St. Catherine and St. James.

Table 1: Seroprevalence of HIV by parish among ANC attendees who participated in the 2017 sentinel survey

PARISH	***2016***			***2017***		
	Total Tested	**Total Positive**	**% Positive**	**Total Tested**	**Total Positive**	**% Positive**
Kingston & St Andrew	1,547	12	0.78	1,313	18	1.37
St Catherine	1,161	8	0.69	1,057	12	1.14
St. Ann	569	5	0.88	523	2	0.38
Clarendon	781	6	0.77	803	2	0.25
St. James	464	4	0.86	460	8	1.74
Westmoreland	695	4	0.58	610	1	0.16
Total	5,217	39	0.75	4,766	43	0.90

Source: HIV Epidemiological Report, 2017

Notable decreases occurred in the parishes of St. Ann, Clarendon and Westmoreland. Since the peak in HIV seroprevalence in 1996, the epidemic has experienced moderate but decreasing fluctuations.

1.3 Transmission risk and Risk groups

Sexual intercourse remains the highest risk factor in Jamaica. Associated history of STI increases HIV transmission risk for both males and females. Further risk occurs primarily among males who have sex with FSW and among females who report multiple sex partners.

Primarily, the main risk groups that have been identified in Jamaica are men who have sex with men, female sex workers, transgender people, adolescents, prisoners, persons with disabilities, women and STI clinic attendees.

Key Population

Men who have sex with men (MSM) accounted for 95% of all key population diagnosis of HIV. This KP also accounts for the highest percentage of new advanced HIV and new AIDS diagnoses (Table2).

Table 2: Key population newly diagnosed with HIV (not AIDS), AIDS, and living with HIV and/or AIDS

Key Populations and Vulnerable Groups	New HIV diagnoses (not AIDS)	New Advanced HIV diagnoses	NewAIDS diagnoses
MSM/Bisexual men	84	18	16
Female Sex Worker	5	1	0
Prisoners	Twelve (12) diagnosed classification is currently unknown		
Transgender	Five (5) diagnosed classification is currently unknown		
Homeless	None reported for 2017		

Source: HIV Epidemiological Report, 2017

The young MSM population accounts for the highest HIV diagnosis (15-24 years =58 and 25- 29 years = 29). In addition, the MSM population had the youngest age group of all the key populations. Female sex workers, prisoners, and transgender persons had no 15-24 year olds diagnosed for the year 2017. Data related to the homeless population were unavailable at time of reporting.

1.3.1 Vulnerable Population

Table 3 shows the age categories and parish of residence, respectively, for new HIV and AIDS diagnoses among vulnerable populations for 2017. Women 45 years and over

account for the highest number of newly diagnosed with HIV and AIDS for 2017 (n=177) followed by the adolescents (15-24 age group).

Table 3: Vulnerable populations newly diagnosed with HIV and AIDS by age, 2017

Key populations and vulnerable groups	15-24	25-29	30-34	35-39	40-44	45+
Adolescents (15-24 years)	67	0	0	0	0	0
Persons with disabilities	No data available					
Women	130	66	76	61	59	177
STI clinic attendees	15	10	11	9	11	23

Source:HIV Epidemiological Report, 2017

1.4 Inclusiveness of Stakeholders in the Report Writing Process

A distinguishing feature of Jamaica's national HIV response continues to be the multi-level, multi-disciplinary involvement of stakeholders. Without exception, this approach extends to the writing of the GAM and NCPI processes.

With the guidance of the lead agency, NFPB, a core technical committee comprising national representatives of the HIV programme, government agencies, CSOs including PLHIV network and bilateral agencies convene to chart an implementation work-plan. Through this work-plan, activities and timelines are scheduled, ensuring on time submission of, and comprehensive information in, the GAM report.

Importantly, this committee was tasked with stakeholder engagement and troubleshooting challenges in the writing process; utilizing diverse approaches to reflect inclusivity of all stakeholders. Among the methods utilized in this process were emails, email reminders, direct telephone calls, individual interviews and workshops. There was also the use of

templates in collecting best practices, primarily among CSO partners. Additionally, draft reports were widely circulated to obtain feedback from participants.

Finally, to bring the individual processes together, the committee presented the draft NCPI and GAM documents to stakeholders. Although the documents would have been previously emailed, the stakeholder workshop held during the final stages of the process concretized feedback and changes through collaborative discussions and activities. After inclusion of feedback, the final document is once more circulated for validation. In keeping with the GAM process, both the Permanent Secretary and The Honourable Minister of Health signed off on the report prior to the official submission to UNAIDS.

2 COMMITMENTS INDICATOR PERFORMANCE (SUMMARY)

2020 Fast-Track commitments		Indicators	Performance
COMMITMENT 1: Ensure that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020	1.1	Percentage of women and men aged 15- 49 living with HIV who know their results	**Overall: 78%** **(2018, HIV EPI Profile/ Spectrum Estimates 2017)** Overall :75% (2016, HIV EPI Profile/ Spectrum Estimates 2017) Overall: 88% (2015, HIV EPI Profile/ Spectrum Estimates 2016) Overall: 81% (2014, HIV EPI Profile/ Spectrum Estimates 2016)
	1.2	Percentage of adults and children currently receiving antiretroviral therapy	**37%: 12453 / 34,000 (2018 – ARV Programme / Spectrum Estimate)** 39%: 11662 / 30,000 (2017 – ARV Programme / Spectrum Estimate) 37%: 10680/29,000 (2016 – ARV Programme / Spectrum Estimate 33%: 9764/29,271 (2015 – ARV Programme / Spectrum Estimate
	1.3	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	**79.9% (2017, ARV Database; For persons initiating Jan – Dec 2017)** 80.4% (2017, ARV Database; For persons initiating Jan – Dec 2016) 58.8% (2016, ARV Database; For persons initiating Jan – Dec 2015) 60.1% (2015, ARV Database; For persons initiating Jan – Dec 2014)
	1.4	Percentage of adults and children receiving ART who were	**66%: 8248/12453 (2018, ARV Database)** 51%: 5949/11622 (2017, ARV Database) 60.7%: 5846/9622 (2016, ARV Database)

2020 Fast-Track commitments		Indicators	Performance
		virally suppressed (i.e.<1000 copies)	45.6%: 4452/9764 (2015, ARV Database)
	1.5	Percentages of people living with HIV with the initial CD4 cell count <200 cells/mm^3 and <350 cells/mm^3 during the reporting period.	**20.4%: CD4 <200 (2018, ARV Database)** **34.6%: CD4 <350 (2018, ARV Database)** 31.6%: CD4 <200 (2017, ARV Database) 49.1%: CD4 <350 (2017, ARV Database) 33.2%: 453/1366 – CD4 <200 (2016, ARV Database) 53.4%: 730/1366 – CD4 <350 (2016, ARV Database) 36.5%: 521/1429 (2015, ARV Database)
Commitment 2: Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018	2.3	Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission	97% - 408/419: (2017, PMTCT Programme Monitoring) 90% - 414/460: (2015, PMTCT Programme Monitoring) 86.4% - 388/449: (2014, PMTCT Programme Monitoring and Spectrum) 88.2% - 410/465: (2013, Spectrum and PMTCT Programme Monitoring)
COMMITMENT 3: Ensure access to combination prevention options, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020, especially	3.3a	Percentage of sex workers living with HIV	**2% of SW (2017, Second generation surveillance)** 2.9% of SW (2014, Second generation surveillance) 4.1% of SW (2011, Second generation surveillance) 7.5% of SW (2008, Second generation surveillance)
	3.3b	Percentage of men who have sex with men who are living with HIV	**29.8% of MSMs (2017, IBBSS Surveillance Survey)** 32.8% of MSMs (2011, Second generation surveillance)

2020 Fast-Track commitments		Indicators	Performance
young women and adolescent girls in high-prevalence countries and key populations—gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners			32% (2007, Second generation surveillance)
COMMITMENT 4: Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020	4.1	Discriminatory attitudes towards people living with HIV	**Overall: 66.8%; Men: 70.6% Women: 63% (2017, KABP survey)** Proportion of men and women 15 – 49 NOT willing to buy vegetables from a vendor they knew was HIV+ Overall: 71.1%; Men: 73% Women: 69% (2012, KABP survey) Proportion of men and women 15 – 49 NOT willing to buy vegetables from a vendor they knew was HIV+ Overall: 28.9%; Men: 27% Women: 30.6% (2012, KABP survey)
COMMITMENT 5: Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020, in order to reduce	5.1	Percentage of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	**Overall: 4%** **Men: 5.4% Women: 1.6% (2017, KABP survey)** Overall: 39% Men: 35.6% Women: 42.8% (2012, KABP survey) 40.2%. (2008, KABP) Men: 37.4% Women: 42.3% (2008, KABP) Women: 59.8% (urban); 57.9% (rural) – (2005, Multiple Indicator Cluster Survey)

<table>
<tr><th>2020 Fast-Track commitments</th><th></th><th>Indicators</th><th>Performance</th></tr>
<tr><td>the number of new HIV infections among adolescent girls and young women to below 100 000 per year</td><td></td><td></td><td></td></tr>
<tr><td>Commitment 8: Ensure that HIV investments increase to US$ 26 billion by 2020, including a quarter for HIV prevention and 6% for social enablers</td><td>8.1</td><td>Domestic and international AIDS spending by categories and financing sources</td><td>
<table>
<tr><th>HIV & AIS Expenditure by Financial Source</th><th>USD 2015/16</th><th>USD 2016/17</th></tr>
<tr><td>Total Spending</td><td>17,828,442</td><td>17,865,905</td></tr>
<tr><td>Public:</td><td>6,950,001</td><td>6,345,447</td></tr>
<tr><td>Percent</td><td>38.9%</td><td>35.5%</td></tr>
<tr><td>International:</td><td>9,146,659</td><td>9,891,106</td></tr>
<tr><td>Percent</td><td>51.3%</td><td>55.4%</td></tr>
<tr><td>Private:</td><td>1,731,782</td><td>1,629,352</td></tr>
<tr><td>Percent</td><td>9.7%</td><td>9.1%</td></tr>
</table>
</td></tr>
<tr><td>Commitment 10: Commit to taking AIDS out of isolation through people-centred systems to improve universal health coverage, including treatment for tuberculosis, cervical cancer and hepatitis B and C</td><td>10.1</td><td>Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV</td><td>There were 0 HIV positive incident TB cases detected in surveillance system and all receive ART 2018 (2018 National TB Programme)

There were 25 HIV positive incident TB cases detected in surveillance system and all receive ART 2015 (2016 National TB Programme)

There were 15 HIV positive incident TB cases detected in surveillance system and all receive ART 2015 (2015 National TB Programme)</td></tr>
</table>

3 2020 Fast-Track commitments and expanded targets to end AIDS

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

The National HIV/STI/Tb Unit began utilising the 'Test and Start' approach as a strategy to achieve the UNAIDS 90-90-90 treatment targets by 2020 in January 2017. Although Jamaica has successfully increased access to treatment and care services (including the 2017 implementation of the WHO Treat All guidelines), analysis of data related to retention in care has shown increased loss-to-follow-up among patients on antiretroviral treatment. Failure to adhere to treatment and care is a barrier to further reducing AIDS morbidity and mortality.

3.1.1 People living with HIV who know their HIV status

An estimated 78% of people living with HIV know their status. This figure will be updated as soon as the 2018 SPECTRUM Estimates become available. In 2017, 184,962HIV tests were conducted by implementing partners in the response, reflecting a marginal increase over 2016. Challenges experienced in 2017 were due to gaps in reporting and delays in test kits. The number of positive tests in 2017 resulted in a yield of 1.9%, which was a slight decrease compared to 2.0% in 2016.

There was a reduction in rejected PCR samples (Table 4). CD4 testing also decreased with a surge in viral load tests, which is probably indicative of initiation of 'Test and Start' in January 2017.

Table 4: Monitoring Tests for 2015-2017

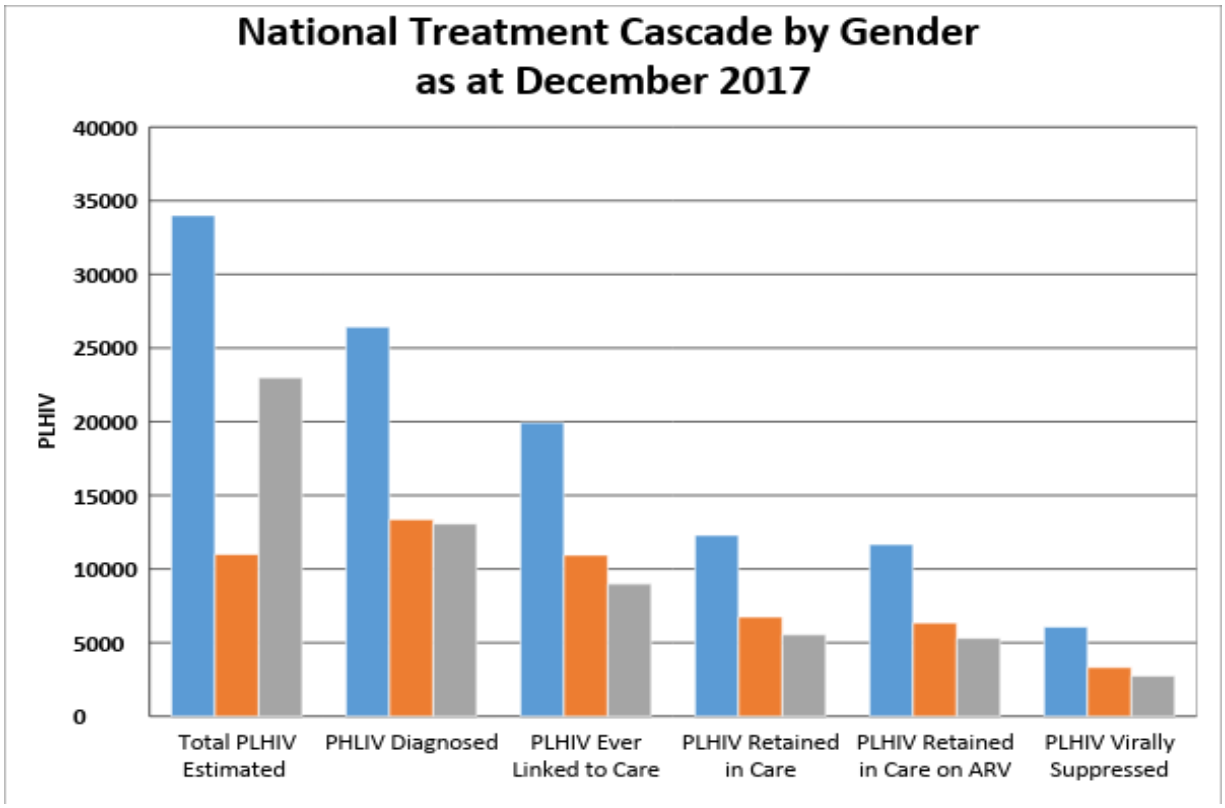
YEAR	PCR			CD4			VIRAL LOAD		
	2015	**2016**	**2017**	**2015**	**2016**	**2017**	**2015**	**2016**	**2017**
Received	978	1,124	982	14,627	14,227	10,295	15,097	17,743	19,232
Processed	912	1,070	953	14,053	13,749	9,956	14,775	17,331	18,917
Positive	11	15	12						
Rejected	66	56	29	574	478	339	322	412	315
Rejection Rate %	6.7	4.9	2.0	3.9	3.4	3.2	2.1	2.3	1.6

Source: NHP Annual Report, 2017

3.1.2 People living with HIV on antiretroviral therapy

Approximately 78% of the estimated number of PLHIV have been diagnosed, 45% of those diagnosed are retained in care on ARVs and 57% of those retained on ARVs are virally suppressed. Much effort is still needed to scale up activities towards achieving significant improvement in the second and third “90’s”.

Figure 5: National Treatment Cascade by Gender, 2017



Source: NHP Annual Report, 2017

Regarding linkage to care, 75% of patients diagnosed have been linked to care, and of those linked, 62% have been retained in care. Of those retained in care, 95% are on ARVs but only 52% of those retained in care and on ARVs are virally suppressed (Figure 5). Through implementing Quality Improvement (QI) activities, there is an emphasis on closing the gaps regarding lost to follow up and viral suppression at all sites and this process will continue into 2018. In order to formalize the institutionalization of QI activities, the Liaison and TCS Officers have been given the responsibility of overseeing implementation and ensuring that all sites have an active QI programme (NHP 2017 Annual Report).

3.1.3 Retention on antiretroviral therapy at 12 months

Significant advancements have occurred in the HIV and AIDS epidemic. Much can be celebrated, such as noteworthy progress towards the elimination of mother-to-child transmission, decline in new HIV infections, decline in late stage HIV/AIDS diagnosis and the exemplary decline in HIV related deaths. However, more is needed as gaps in the continuum of care continue to pose a problem especially in the areas of linkage and retention in care, and ARV coverage and viral suppression. These are compounded by barriers to care such as stigma and discrimination, staff shortages, inadequate linkages with civil society and private sector organizations among others. Nonetheless, stakeholders continue to employ creative and new strategies to resolve these challenges.

The 2017 national treatment cascade illustrates several areas of deficiencies in the continuum of HIV treatment and care. The health system faces several barriers to implementing routine HIV testing as evidenced by 78% that have been diagnosed. Additionally, Provider Initiated Testing Counselling (PITC) in Accident and Emergency departments at some facilities remains low, especially among patients admitted to hospitals.

There has been a scale up of PITC training and intervention across the Regional Health Authorities (RHAs) and reinforcement from the national level, which has resulted in an improvement in uptake. This effort will be sustained in the coming year.

3.1.4 People living with HIV who have suppressed viral loads

Viral load testing is a critical clinical indicator in monitoring patient response to treatment. It helps to determine how well the immune system is fighting the virus. Jamaica's national guidelines dictate that viral load assessment should be done six months after starting ARV and then twice annually until the patient is virally suppressed. Thereafter the test should be conducted annually.

In 2017, viral load testing increased by 11% compared to the previous year. There was a reduction in the number of rejected samples and other quality concerns are being addressed by the National Public Health Lab (NHPL).

NHPL implementation covered the following guidelines:

1. A direct telephone line was established at Sample Reception so that sites are able to call directly to check on the status of their results.
2. A line listing template was developed so that the sites can document pertinent information about the samples that are being sent as well as use the tool to follow up on the results.

Through a quality improvement activity, the NPHL has tested these two interventions using Plan Do Study Act (PDSA) cycles and have found them to yield some level of success in improving efficiency.

Additionally, the HSTU in collaboration with University of California, San Francisco, is in the process of merging the Treatment Site Information System (TSIS) and DISA Lab. This is a tremendous step for access to viral load testing. Sites that have completed the merger are able to access viral load results in real time, provided that the information in TSIS is identical to the information in DISA Lab.

In 2018, the TCS Component of the HSTU embarked on several activities to bolster retention and adherence:

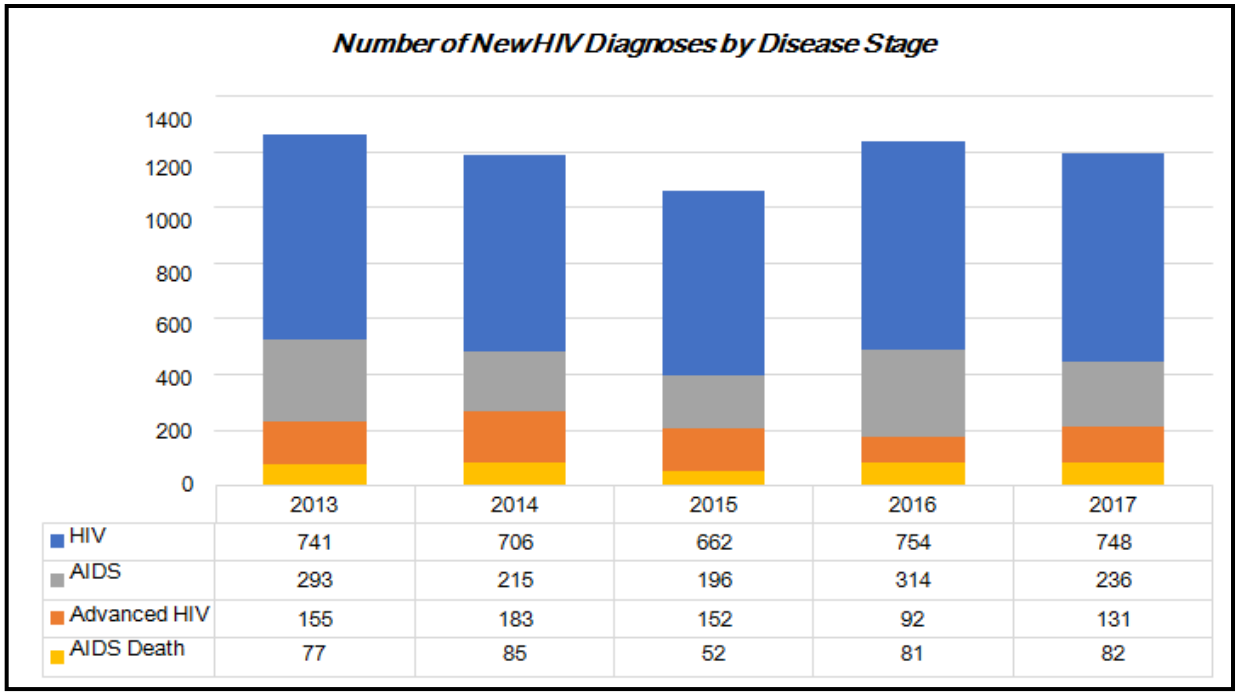
1. Capacity building of staff:
    a. Formalisation of training curriculum for Adherence Counsellors
    b. Training of Adherence Counsellors in the above curriculum
    c. Training of Case Managers
    d. Stigma & Discrimination Training of all levels of staff
2. Increase in the number of Private Pharmacy Providers
3. National Case reviews for PMTCT

4. Development of an Enhanced Package of Care for Key and vulnerable populations

3.1.5 Late HIV diagnosis

Over a 5-year period, new HIV diagnoses by disease stage has not shown a remarkable decrease in diagnosis at the advanced HIV stage from the base year 2013 to 2017. Contrarily, in Figure 6, there have been slow, steady fluctuations in the diagnosis at death. Of note, 2015 had the lowest percentage of new diagnoses classified as AIDS and AIDS deaths.

Figure 6: New HIV diagnoses by Disease Stage, Jamaica, 2013–2017



	2013	2014	2015	2016	2017
HIV	741	706	662	754	748
AIDS	293	215	196	314	236
Advanced HIV	155	183	152	92	131
AIDS Death	77	85	52	81	82

Source: HIV Epidemiological Report, 2017

The year 2016 had the highest percentage of new diagnoses classified as AIDS. Compared to previous years, 2017 had one of the higher numbers of cases diagnosed at the HIV stage, however the year also saw seven percent of cases newly classified at death.

3.1.6 Antiretroviral medicine stock-outs

A constant supply of ARVs is essential to support an effective treatment response. Contrary to 2016 when the country experienced ARV stock-outs, the country learned a few lessons that averted stock-outs in 2017. Included in the changes were forecasting and planning mechanisms to prevent national stock-outs of ARVs and the implementation of Quantimed and Pipeline software. These efforts were supported through the assistance of USAID as well as other funding partners.

The Quantimed and Pipeline software assists with the forecasting of ARV needs and allows planned ordering of ARVs based on data inputted relating to the number of patients on the various treatment regimens, usage pattern and expected attrition, movement between treatment lines and number of new cases detected.

Increased collaboration and partnership with the NHF have also been established. Additionally, an in-house ARV tracking tool was developed to manage the logistics of ARVs management and good quality practices associated with distribution. As part of the ARV management strategy, quarterly meetings with the NHF was also introduced.

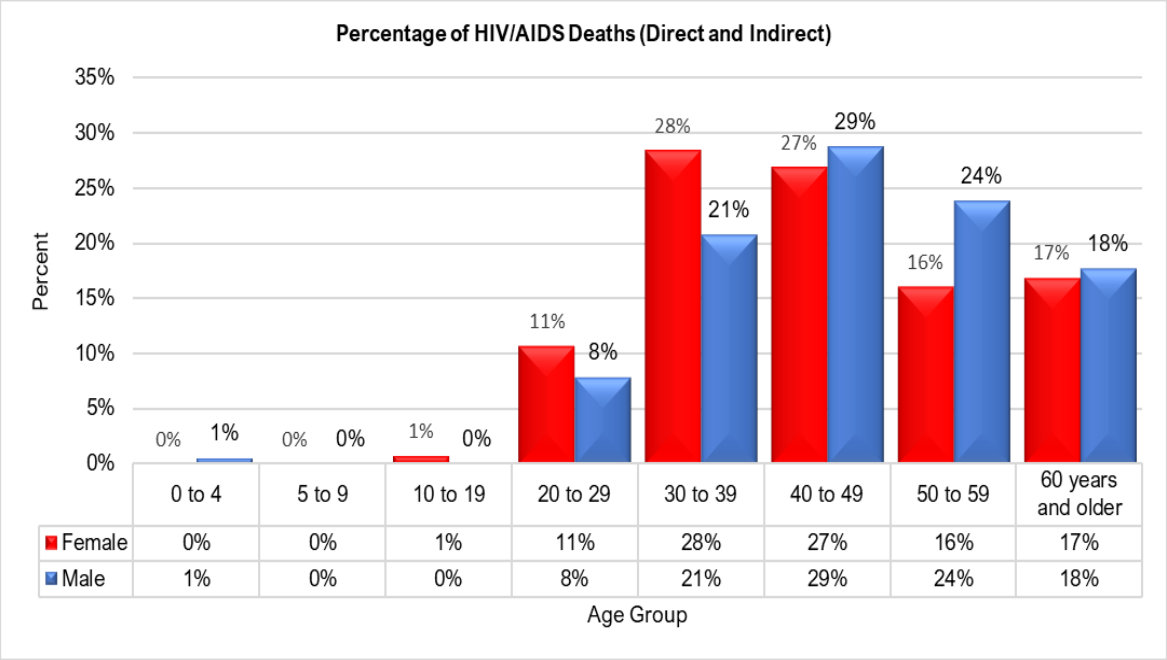
During 2017 and 2018, Global Fund pooled procurement mechanism (WAMBO) process facilitated the procurement of ARVs. There was a stock-out period which affected some treatment sites. However, recirculation of country-level ARVs between ARV dispensing pharmacies minimized the interruption of patient treatment and prevented patients from being switched to alternate regimens.

To maintain quality standards, a quality assurance plan was developed in 2018 with the assistance of the USAID. The goal is to ensure the highest quality of ARV drugs are obtained at the best price without interruption using the through the WAMBO process.

3.1.7 AIDS mortality

As a whole, males experience higher direct and indirect AIDS mortality compared to females. Yet, within the younger age groups of 20-39 years, females out number males in direct and indirect mortality. Figure 7 shows that a higher percentage of deaths occur between ages 40 to 59 years, signalling the need to scale up treatment, care and support for people living with HIV. Ensuring PLHIV experience longer and healthier lives is foundational to the national programme.

Figure 7: HIV/AIDS deaths (direct and indirect) by Sex and Current Age Group, Jamaica, 2017



Source: HIV Epidemiological Report, 2017

3.1.8 HIV testing volume and yield

In 2018, HIV testing was primarily focused on key populations most at risk of HIV transmission. The following tables provide overview of HIV testing volume and yield (number of people testing HIV positive) by target population, age, service delivery modalities and by the type of testing services.

3.1.8.1 HIV Testing Volume and Yield by Target Population

Table 5: HIV Testing Volume and Yield by Target Population

Target Population	**MSM**	**FSW**	**TG**	**DU**	**Unknown**
Positive	336	45	47	0	1
Total	5031	5342	312	6	249
Percentage	**6.7%**	**0.84%**	**15%**	**0%**	**0%**
Target Population	**GP**	**OSY**	**Inmates**		**Total**
Positive	201	10	50		**690**
Total	43489	1706	1410		**57,545**
Percentage	**0.46%**	**0.59%**	**3.55%**		**1.2%**

At the time of this report, the testing volume in key populations in 2018 through outreach interventions was a total 57,545 persons. In Table 5, 5,031 Men who have sex with men (MSM) were tested. Additionally, 5,342 female sex worker (FSW), 312 transgender (TG), 6 drug user (DU), 43,489 general population (GP) persons, 1,706 out of school youths (OSY) and 1,410 inmates and 249 persons of an unknown population were tested. Regarding the testing results, a total of 690 persons tested positive for HIV among the target populations. This constitutes 336 MSM, 45 FSW, 47 TG, 201 GP, 10 OSY, and 50 inmates 1 of an unknown population. Of note, TG (15%), MSM (6.7%) and inmates (3.55%) demonstrated higher yield among these key populations, indicating the need for grate input of resources in reaching these populations.

3.1.8.2 HIV Testing Volume and Yield by Total and Age

Table 6 represents 2018 HIV testing volume and yield by age group. Overall, 57,545 HIV tests were performed; denoting where results were delivered and pre and post-counselling

completed (testing volume). Of this amount, 690 (1.2%) tested positive and received the results (yield). The table also indicates that although females (15+) represent more than half of those tested, they accounted for less than a third of the yield. Furthermore, it should be taken into consideration that most of the 494 males that tested positive for HIV were from the MSM and TG target population (refer to Table 4 above).

Table 6: HIV Testing Volume and Yield by Total and Age

	Total	**<15**	**Males 15+**	**Females 15+**	**Unknown**
Percentage of HIV-positive results returned to people in the calendar year	1.2%	0%	2.1%	0.58%	0.75%
Number of tests conducted where an HIV- positive result was returned to a person (yield)	690	0	494	190	6
Number of tests performed where results were received by a person (testing volume)	57,545	108	23773	32860	804

3.1.8.3 HIV Testing Volume and Yield by Service Delivery Modality

In 2018, service delivery modalities included home based, site based, venue based and other (captures random and ad hoc testing modalities). As per Table 7, 1,826 tests were performed with home-based modality, 19,834 at a site based modality, 33,188 at a venue based modality and 909 at other forms of modalities including skills-base and 1,788 from unspecified modalities. Among the tests that were performed, 40 positive results were identified under home based modality, 189 under site based modality, 385 by venue based modality and 18 from other modalities and 58 from unknown modalities.

Table 7: HIV Testing Volume and Yield by Service Delivery Modality

	Home Based	Site Based	Venue Based	Other	Unknown
Percentage of HIV-positive results returned to people in the calendar year	**2.2%**	**1.0%**	**1.2%**	**2.0%**	**3.2%**
Number of tests conducted where an HIV-positive result was returned to a person (yield)	40	189	385	18	58
Number of tests performed where results were received by a person (testing volume)	1,826	19,834	33,188	909	1,788

3.1.8.4 HIV Testing Volume and Yield by Testing Services

In 2018 a total of 19,834 HIV tests were performed at mobile testing service, 3,257 at VCT centres and 21,757 were performed at other testing services (Table 8). With respect to the number of HIV test conducted where an HIV positive result was returned, 189 were from mobile services, 225 were from VCT centre services and 200 were from other services and 76 were form unknown testing services. The VCT centre, located at health centres, realized the highest percentage of HIV positive results despite representing the least number of tests performed among the three testing services.

Table 8: HIV Testing Volume and Yield by Testing Services

	Mobile	VCT Centre	Other	Unknown
Percentage of HIV-positive results returned to people in the calendar year	**1.0%**	**1.7%**	**0.9%**	**2.8%**
Number of tests conducted where an HIV- positive result was returned to a person (yield)	189	225	200	76

Number of tests performed where results were received by a person (testing volume)	19834	13257	21757	2697

3.1.9 Mentoring to PLHIV Community Facilitators

Working with PLHIV to build capacity to expand treatment and adherence interventions, the Enabling Environment and Human Rights (EEHR) collaborated with the Jamaica Network of Seropositives (JN+) through GIPA (Greater Involvement of People Living with HIV) Unit to build the adherence and retention capacity of PLHIV. Components provided were promotion and transfer of knowledge on Positive Health, Dignity and Prevention (PHDP) and skills to engage and access health and other support needs. The NFPB provided mentorship for the Community Facilitators' Deployment Initiative for PLHIV leadership in adherence and retention support. This is part of broader efforts geared at more meaningful GIPA through integration of the PLHIV in the national response by improving their abilities to participate, facilitate sessions and workshop for greater understanding of the issues pertaining to PLHIV and key population communities and to enable community leaders (including new, young, and potential) to represent their community's HIV health-related challenges and solutions.

The Community Facilitators were deployed to each Regional Health Authority by JN+ to liaise with select members of the health team on matters relating to the conduct of self support groups and treatment adherence, and were assigned especially to PLHIV-peers who belong to Key Population groups and who were lost to follow-up or experiencing challenges that resulted in their inability to adhere to Treatment, Care and Support Services.

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

3.3 Early infant diagnosis

Provider Initiated Testing and Counselling is the hallmark of antenatal interventions at both public and private health care facilities at the sub-national level. PMTCT reporting captured outcome and final status of delivered infants and appropriate treatment inclusive of drugs and dosing.

3.3.1 Challenges

Challenges were noted as comparatively lower for HIV than for Syphilis. This was accompanied by less than ideal documentation of the clinical follow-up, which included treatment of the mother and infant pair; however, this was quickly addressed.

The HSTU introduced the Maternal Syphilis and Syphilis Exposed Infant Registers. This tool captured key areas previously missed in Syphilis screening. Following the development, PMTCT Coordinators, Nurses, Clinicians and relevant support staff such as Regional Coordinators, Contact Investigators (CIs), Social Workers and Adherence Counsellors were trained in the use the updated data collection tools. The relevant private sector health care workers (HCWs) were also included to enable an all-encompassing national response.

3.4 Preventing the mother-to child transmission of HIV

Key among Jamaica's priorities in the programme level adoption of WHO target in the Americas is the Elimination of Mother-To-Child Transmission (EMTCT) of HIV & Syphilis by 2015. This is evidenced by complete integration in Jamaica's National Integrated Strategic Plan (NISP) for Sexual and Reproductive Health, ensuring the efforts of the HSTU aligns with those of the Family Health Unit (FHU) and the NFBP, the two main providers of SRH care in the island.

Multi-level strategies have taken shape to provide not only the scale-up of surveillance but a coordinated and inclusive approach. There is a national focal point with the responsibility for managing with support from the EMTCT Oversight Committee inclusive of

paediatricians, gynaecologists, past Jamaica Paediatric, Perinatal and Adolescent HIV/AIDS Programme (JaPPAIDS), UNJT and civil society.

In keeping with the latest WHO standards, the PMTCT program has set out to achieve:

- 2% or less rate of MTCT for HIV
- 0.3 per 1000 live births annual rate of new infections of HIV and
- 0.5 per 1000 live births annual rate of Congenital Syphilis

Table 9: EMTCT validation indicators for Jamaica 2015 – 2017

Impact indicators	**Target**	**2015**			**2016**			**2017**		
		Result	Num	Den	Result	Num	Den	Result	Num	Den
HIV MTCT rate	**<2%**	1%	5	345	1%	5	429	6%	16	270
Annual rate of new inf. Per 1000 infections	**<0.3**	0.13	5	37,556	0.139	5	35,959	0.47	10	33,979
Annual rate of CS per 1000 live births	**<0.5**	0.08	3	37,556	0.22	8	35,959	0.24	8	33,979

Source: NHP Annual Report, 2017

The target for HIV MTCT rate was not met for 2017 (Table 9) and up to the time of this report, 2018 figures were not available. Among other nascent strategies to analyse the root cause of not achieving the target are a detailed case-based investigation of EMTCT process gaps and EMTCT Oversight Committee deliberations as to the best approach for managing this emergent challenge.

3.4.1 The Way Forward

In 2018, all efforts continued to be geared towards Jamaica's achievement of Elimination status. Maintenance of this status involves the following:

1. Proper PITC testing at all labour wards and delivery suites in the 3rd trimester and for un-booked mothers. This gap was made evident by the 2017 PMTCT programme analysis and the results of an ongoing Site Mentoring Team evaluation.
2. Improved user-friendly data collection mechanisms with a by-product of enhanced monitoring and evaluation of the programme through:
    a. A web-based PMTCT monthly reporting form capable of producing comprehensive annual reports that may be site specific, region specific or give the national picture, inclusive of specific EMTCT indicator filtering that aids in donor reporting mechanisms.
    b. Offered consultancies with organizations such as the University of California San Francisco (UCSF) on improved data visualization to improve delays in implementing corrective measures for each site and motivating sub-national staff in the achievement and maintenance of elimination targets.
3. Capacity Building through: the employment of an EMTCT National Validation Field Coordinator to monitor and bridge programme gaps between the national and sub-national level; printing of the updated PMTCT Manual and Easy Reference Guides and continued training of staff, at both national and sub-national levels of programme management, on updated PMTCT protocols and guidelines. These will be made possible with funding assistance from UNJT.
4. Sustainability of the programme supported through the GOJ budget providing programme specific funding for 2018/2019, this includes the absorption of the cadre of PMTCT Nurses by the regions. Further, the adaptation of EMTCT plus, to include the MTCT of Hepatitis B, as prioritized by the WHO.

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

3.5.1 Estimates of the size of key populations

Size estimates for key populations were undertaken in 2018. These were done in conjunction with the integrated biological and behavioural surveys among MSM, Transgender persons and sex workers. A combination of different methods were utilized, these included unique object multiplier, the wisdom of the crowds, service multiplier, literature review and a synthesis of methods using the anchored multiplier. Additionally, national bio-behavioural surveys contributed to these estimates. Notable 2017 and 2018 studies included:

- Bio-Behavioural Surveillance Survey of Female Sex Workers
- Bio-Behavioural Surveillance Survey of Men who have Sex with Men
- Annual HIV Sentinel Surveillance, and Sero-survey and Knowledge
- Attitude, Behaviour and Practice (KABP) Survey.

Additionally, broad and extensive consultations played a key role in advancing size estimates for key populations. Contributors included national and international academic experts, epidemiologists, civil society experts on key populations, UNAIDS, UNICEF, and government officials.

Table 10 represents the estimated size of Jamaica’s key populations.

Table 10: Estimates of the size of key populations

Key population	2018estimated population
men who have sex with men (MSM)	42,375 (95% CI: 28,278 – 58,855)
transgender (TGW)	3,841 (95% CI: 3,142 – 4,646)
sex workers and their clients	18,696 (2014)

Source: 876 Study: Integrated Biological & Behavioural Surveillance Survey with Population size estimation among MSM & TG in Jamaica. Ministry of Health, 2018.

3.5.2 HIV risk behaviour

Table 11 defines risk as ever been exposed. Meaning, newly diagnosed persons may reflect one or multiple risk behaviours at time of diagnoses. The highest risk history among males was multiple partners, while among females it was sexually transmitted infection. The top three in risk history among males were multiple partners (26.8%), STI (21.5%) and sex with FSW (15.8%).

Table 11: Risk behaviour of newly diagnosed HIV cases in Jamaica by gender, 2017

Risk Behaviour	Male (%)	Female (%)
Crack/cocaine use	3 (1.3%)	1 (0.7%)
Intravenous drug use	2 (0.9%)	1 (0.7%)
Sex Transmitted Infection	49 (21.5%)	63 (41.2%)
Genital Ulcers/sores	7 (3.1%)	7 (4.6%)
Sex with FSW	36 (15.8%)	1 (0.7%)
FSW	2 (0.9%)	6 (3.9%)
Unprotected anal sex	16 (7.0%)	0 (0.0%)
Multiple partners	61 (26.8%)	35 (22.9)
Ever in prison	10 (4.4%)	2 (1.3%)
Victim of assault	7 (3.1%)	11 (7.2%)
Sex with known PLHIV	13 (5.7%)	10 (6.5%)

Transactional sex	17 (7.5%)	9 (5.9%)
Perinatal exposure	0 (0.0%)	1 (0.7%)

Source: HIV Epidemiological Report, 2017

The three highest for risk history among females is STI (41.2%), multiple partners (22.9%) and victim of assault (7.2%) as per Table 11. Similar to the cumulative risk history profile, intravenous drug use[1] and perinatal exposure remain below one percent for both males and females.

Table 12 illustrates that heteronormative sexual practices dominate reported newly diagnosed. The 2017 the data captures a higher number of men who have sex with men. This may be attributed to improved data collection and quality of the data collection process in conveying risk factor information.

Table 12: Sexual practices of newly diagnosed HIV cases in Jamaica by gender, 2017

Sexual Practices	Male (%)	Female (%)
Heterosexual	335 (54.29)	565 (98.09)
Homosexual	82 (13.29)	0 (0.00)
Bisexual	38 (6.16)	1 (0.17)

Source: HIV Epidemiological Report, 2017

3.5.3 HIV prevention and testing among key populations

The prevention of HIV is a priority for the National HIV/STI Programme. The Primary model used to guide the strategy development and effectively implementation is Behaviour Change and Communication (BCC). The National Family Planning Board (NFPB) leads the prevention implementation through BCC teams across the four (4) Regional Health

[1]In Jamaica, although drug use is a high-risk factor for HIV transmission, injecting drug use is not a recognized risk factor.

Authorities – South-East (SERHA), North-East (NERHA), Western (WRHA) and Southern (SRHA)to include civil society across regions.

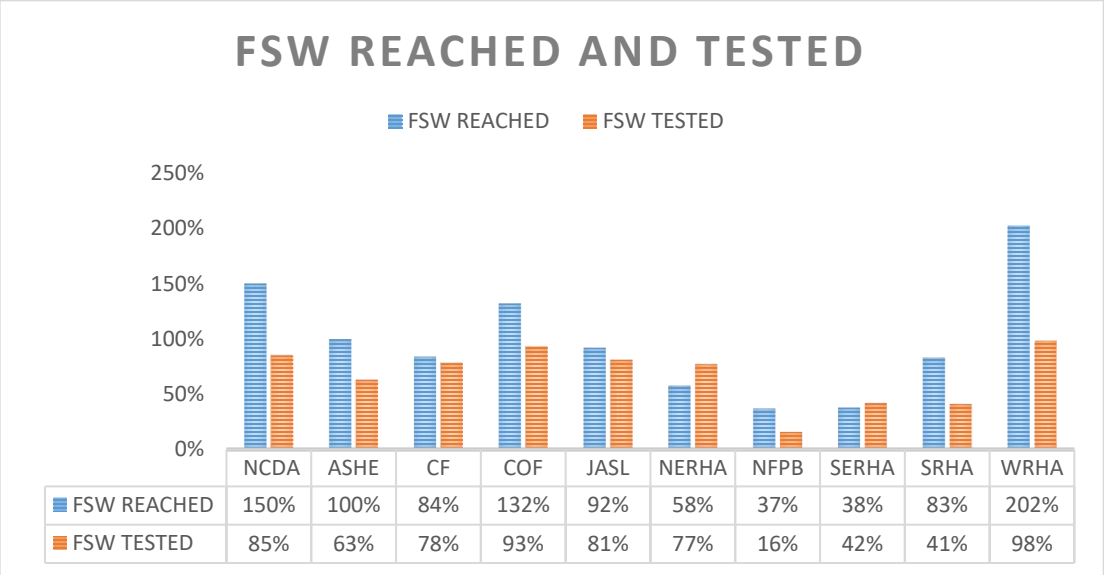
Bolstered by partnerships with government, private financial Institutions, non-government organizations (NGO), bilateral agencies and community-based organizations (CBOs), the Prevention component is able to make substantial impact. Partnerships were valuable in addressing some of the social, economic, political and cultural challenges that would have impacted implementation and ultimately, the achievement of programme targets.

3.5.4 HIV testing among sex workers

In 2018, a total of 10,148 female sex workers were reached with a comprehensive package of prevention services to include 181,163 condoms distributed and resulted in 5,342 tests (Figure 8). The number reached represented 90.7% of the prescribed sex work targets. However, only 66% of the test targets were realized, which speaks to the need to scale up targeting ratio among sex workers. Female sex workers were engaged in clubs, street sites, massage parlours and bars. Reaching female patrons and female staff in these venues was intentionally emphasized as studies have shown they are also sometimes engaging in sex work.

Between 2015 and 2017, HIV prevalence decreased from 2.9% to 2% among female sex workers. Quite possibly, the decrease may be attributed to the continuous engagement of the Prevention team. Additionally, figure 8 provides additional details as to the reach and spread of testing across the country.

Figure 8: FSW Reached and Tested in 2018



	NCDA	ASHE	CF	COF	JASL	NERHA	NFPB	SERHA	SRHA	WRHA
FSW REACHED	150%	100%	84%	132%	92%	58%	37%	38%	83%	202%
FSW TESTED	85%	63%	78%	93%	81%	77%	16%	42%	41%	98%

Source: Prevention Annual Report, 2018

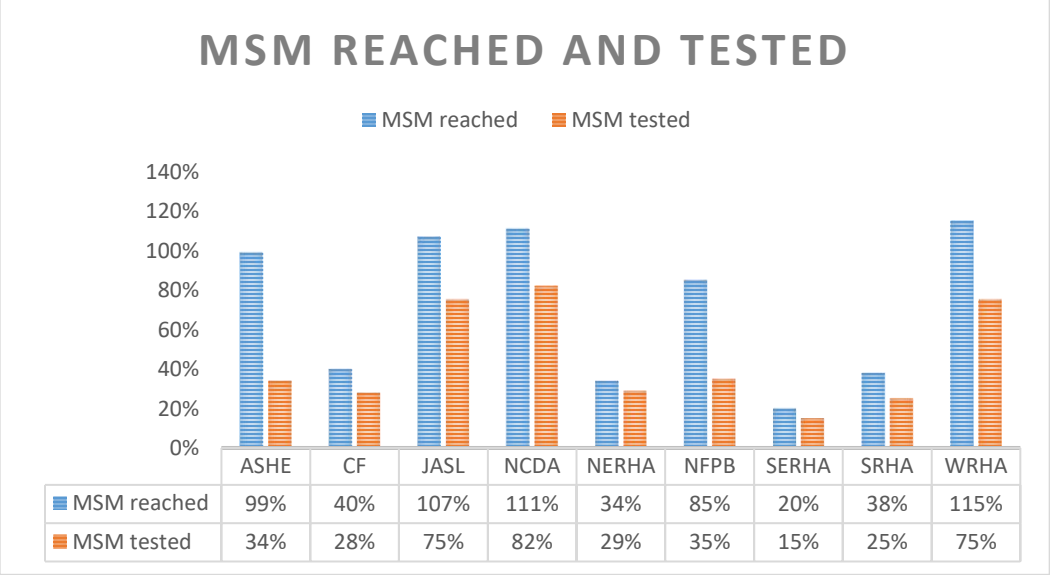
3.5.4.1 Challenges

- **Identifying new sex work sites:** Locating new sex work sites has become problematic because sex work is accessed differently. Sex work is now believed to now heavily in the exit digital realm or in less formal spaces. Therefore, our experience shows less impact in engaging in traditional sites.
- **Migratory nature of FSW resulting in duplication of efforts:** The population is very mobile; reducing opportunities for continuous interventions and monitoring. FSW move from one parish or region to another, which leads to multiple agencies reaching and testing the same persons.
- **Increase in the use of social media:** Access to social media and mobile devices has increased work from home options for FSW; making site-based interventions more difficult.
- **Line of demarcation between transactional sex and traditional sex work has become blurred.**

3.5.5 HIV testing among men who have sex with men

Jamaica also experiences a concentrated HIV epidemic. Strategieshave sought to embrace both broad-based and targeted interventions. Among broad based strategies, these included workshops, skills building, site based and venue based interventions, use of peer links, one to one and snowballing. Additionally, efforts were made to increase workplace interventions in hotels and call centres and to use parties or lymes as spaces for outreach. Social media was used as a tool to further increase reach and testing of the population.

Figure 9: MSM Reached and Tested in 2018



	ASHE	CF	JASL	NCDA	NERHA	NFPB	SERHA	SRHA	WRHA
MSM reached	99%	40%	107%	111%	34%	85%	20%	38%	115%
MSM tested	34%	28%	75%	82%	29%	35%	15%	25%	75%

Source: Prevention Annual Report, 2018

Priority for Local AIDS Control Efforts (PLACE) methodology was utilized to identify key population sites for interventions (Table 9 capturing MSM reached). Country-wide PLACE sites included popular restaurants, plazas/malls in the main town centres in the parishes, private homes, and churches. Site interventions covered HIV prevention activities such as basic facts on HIV/STI, risk assessment and risk reduction conversations and discussions, and condom use skills building. As a standard package of services, all interventions provide distribution of condoms and lubricants to the population. Figure 9 shows the distribution of MSM reached and tested across the four regions. A total of 10,748 men were reached and 5,031 were tested. The number reached represented 77% of the

allocated target, while 45% of the target were tested. Since 2011, HIV prevalence among MSM has remained at 32% with a slight decrease to 29.8% in 2018.

3.5.6 HIV testing among inmates

Partnership with the Department of Corrections facilitates prevention activities within prisons. The prevention teams routinely deliver interventions to four correctional institutions: Tower Street Adult Correctional Centre (TSACC), St. Catherine Adult Correctional Centre (ST. CACC), Tamarind Farm Adult Correctional Centre (TFACC) and Fort Augusta Adult Correctional Centre (FAACC) for women. One on one and group educational sessions continue with special emphasis on 'test and start'. Educational sessions are also done with visiting family members and friends at the visitor's area at TSACC and STCACC.

Additionally, through further collaboration with Health Through Walls (HtW), a civil society organization, additional testing was delivered in Horizon Adult Remand Centre (HARC), New Broughton Adult Correctional Centre (NBACC), and Richmond Farm Adult Correctional Centre (RFACC).

Table 13: Inmates Tested at four Correctional Facilities

Facility	Tested	HIV+	Syphilis
TSACC	634	19	14
FAAC	57	0	1
STCACC	658	31	17
TFACC	38	0	3
Unknown	23	0	0
TOTAL	**1,410**	**50**	**35**

Source: Prevention Annual Report, 2018

Cumulatively, at four correctional facilities, 1,410 tested for HIV and Syphilis with 50 new cases of HIV and 35 Syphilis were identified (Table 13). Testing figures also includes 14 self-identified MSM and 2 FSW. All persons reactive for HIV and Syphilis are successfully linked to care.

3.5.7 Bio-Behavioural Surveillance Survey of Inmates

The second Bio-Behavioural Surveillance survey was completed in 2018. Seven hundred and twenty-six (726) inmates participated from four correctional facilities in Kingston and St. Catherine. The findings from the survey indicated HIV prevalence of 6.9% and Syphilis prevalence of 4.5%. Additional findings revealed HIV knowledge was surprisingly low and inmates found adherence to medication to be challenging. Re-strategizing of the prevention interventions in prisons remains a policy anomaly.

As next steps, there will be a restructuring of the prevention activities within these facilities. Key components are interval testing of inmates, ongoing training of staff and inmates, development of a peer educator programme, as well as increased interaction with inmates and visitors. As an outcome, both inmates and visitors will experience increased knowledge in sexual and reproductive health.

3.5.8 Challenges

- Significant delay in results from National Public Health laboratory.
- Some inmates refuse to get their blood work done for varying reasons including denial of their HIV status.
- Inmates, including those who are HIV positive, are being transferred to other correctional institutions without their medical charts. This created additional challenges for follow up care in the correctional system.
- Staffing challenges. Difficulty of assigning escorts to Programme Officers.
- The treatment of condoms in prison as contraband makes it difficult for inmates to practice safe sex.

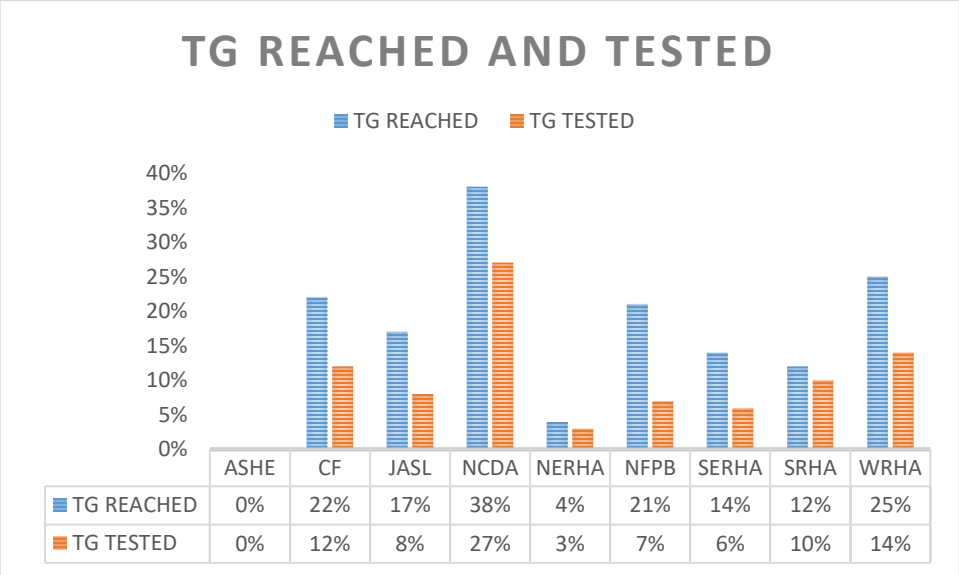
3.5.9 HIV testing among transgender people

Key among the mandates of the National HIV Programme, is the provision of optimal health and safer sex practices for persons of trans experience. To achieve this goal, there remain a number of challenges. Primarily, because the trans community is made up of diverse people, inclusive of trans-masculine, trans-feminine and non-binary identities.

Additionally, there are persons who also may not necessarily identify as trans or gender non-conforming but fits within the LGBTIQ spectrum. Although trans people fit within the spectrum, their gender identity is separate from the sexual orientation and as such, they can also identify as LGBQ. This means that the sexual and reproductive health needs and interventions of trans persons are important to consider. Although challenges are real, CSOs and government creatively implement programmes to engage our hardest to reach population, transgender people.

Figure 10 provides an overview of the HIV testing across the country.

Figure 10: TG Reached and Tested in 2018



	ASHE	CF	JASL	NCDA	NERHA	NFPB	SERHA	SRHA	WRHA
TG REACHED	0%	22%	17%	38%	4%	21%	14%	12%	25%
TG TESTED	0%	12%	8%	27%	3%	7%	6%	10%	14%

Source: Prevention Annual Report, 2018

Importantly, as next steps, TransWave Jamaica, a civil society organization led by members of the Transgender community. They have supported the government's BCC team through training and capacity building to understand the behaviour of the trans population and to improve the design of interventions.

3.5.10 Challenges

- **Incentivized Participation:** Lymes are mostly attended by MSM/TG from the lower SES that have admittedly been to several other workshops. They have also become

accustomed to receiving stipends for participating in programmes and have become unwilling to participate in interventions unless monetary incentives or care packages are being offered.

- **Lack of safe spaces:** This hampers the progress of the intervention as team members are hesitant to work at known MSM sites for fear of flare-up of violence or police raids. Threats of violence compromise both staff and participants.
- **Lack of safe spaces within community:** Persons who identify as MSM within the upper socio-economic scale are reluctant and often unwilling to share space with persons of trans experience.
- **Real and perceived stigma**: Stigma is a real challenge to programme implementation. Persons fearful of receiving a positive result tend not to access testing services. 'Test and start' is a programme strategy, a method to dispel fears.
- **Hormone replacement therapy:** Public health care system does not offer hormone replacement therapy as an option of care. Transgender people have resorted to self-medicating, using high dosages of oestrogen. Major challenges witnessed include side effects and serious adverse reactions. Individuals face discrimination within the public health system when accessing treatment for these symptoms. Where possible, private care is accessed to treat any possible side effects resulting from self-medicating and any sexually related infections.
- **Empowerment:** The transgender community are seen as individuals with fluid gender identity. However, most do not identify with the community but rather identify with the MSM community. This severely restricts the ability for the prevention team to offer the best package of services, mitigate challenges for treatment and to tailor services unique to the transgender population.

3.6 CONDOM DISTRIBUTION

In 2018, over 3 million condoms were distributed through established condom distribution outlets across the regions and outreach activities (table 14). Civil society organizations continue to share in reaching communities and distributing commodities including as male

condom distribution. Government agencies distributed substantial amounts of male condoms to impact communities.

Table 14: Summary of Condom Distribution, 2018

CONDOMS	Public	Private	NGOs	TOTAL
Condoms distributed	2,456,420	59,928	794,228	3,310,576

Source: Prevention Annual Report, 2018

3.6.1 Demand for family planning satisfied by modern methods

Condoms serve as dual purpose: Prevention of pregnancy and prevention of contracting sexually transmitted infection (STI).

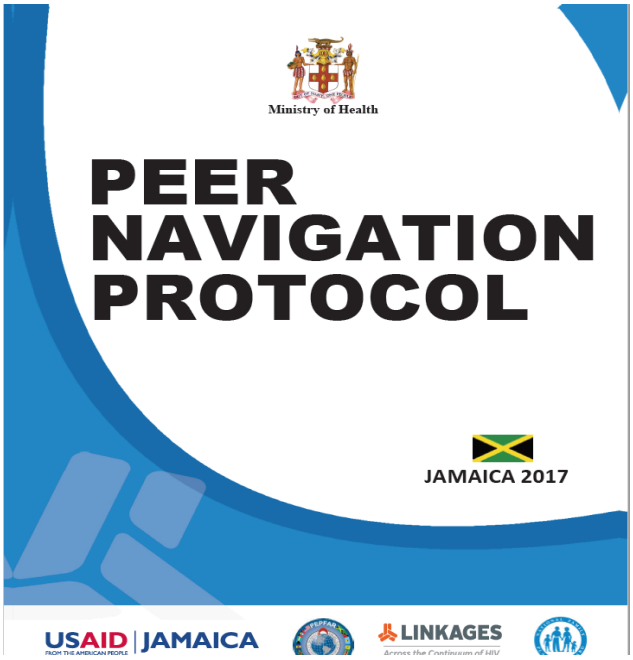
Arising from the NFPB's High Risk Community Contraceptive Need Study 2018, it was noted that on average, male condom users represented 61% of overall contraceptive use. However, it was predicted that the condom needs for private users over the period 2019, 2020 and 2021 would likely be 35,766,360; 38,407,560; and 38,573,880 respectively. In terms of public user needs, this would likely represent 1,666,800; 1,789,920; and 1,797,600 respectively over the said period. A contraceptive forecasting plan was completed.

The objectives of developing a Contraceptive Forecasting Plan were to:

1. Forecast the current contraceptive need for all women within the reproductive age group 15-49 in Jamaica;
2. Determine the contraceptive method mix for the public and private sector clients;
3. Determine the minimum and maximum stock level for each contraceptive method at the national level;
4. Reduce stock-out of contraceptive method through the Contraceptive Logistic Management System (CLMS).

3.7 Peer Navigation

The Peer Navigation programme is a method whereby trained outreach workers within the Prevention Program work as part of the treatment team to assist HIV-positive beneficiaries



enrol in and access care and treatment services. Additionally, outreach workers support PLHIV to identify and mitigate social determinants of health, positioning beneficiaries to achieve better health outcomes.

In 2015, the Peer Navigation model was introduced in Jamaica. The rationale for its introduction was to improve Jamaica's treatment cascade, which showed significant fall-off along the spectrum of care. The model sought to improve the number of persons linked to care and ARVs and achieving viral suppression. In an effort to build capacity in-country, Linkages Jamaica in 2016 facilitated a 5-day Training of trainers' workshop in addition to several consultations with stakeholders.

This initiative grew into regional trainings and resulted in 120 peer navigators and their supervisors being trained. Training themes included Concepts of Peer Navigation, the HIV cascade, Gender & Sexual Diversity, the Multidisciplinary team, HIV 101, Motivational interviewing, hotspot mapping & validation, Microplanning, using forms and tools for client tracking, Key population risk profiling, development of HIV in the body, an orientation to Treatment literacy, how to navigate a client through Disclosure of HIV status, and Navigating clients through the treatment and care system. These trainings were held for both government and CSOs in the four health regions of the Ministry of Health.

In 2017, USAID officially presented the Ministry of Health with the National Peer Navigation Protocol, developed and supported by the Ministry of Health, Regional Health Authorities, National Family Planning Board and CSOs. The Protocol provided the first guide to the practical implementation of the peer navigation system. In addition, the Protocol provided tools for documentation of job description for navigators and supervisors.

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

3.8.1 Discriminatory attitudes towards people living with HIV

Stigma, discrimination and human rights receive ongoing attention from the government, civil society and bilateral agencies. In a 2017 KAPB, only 1 in 10 persons displayed accepting attitudes towards PLHIV. Key populations including PLHIV, MSM and transgender persons continued to face discrimination among different settings, including in communities and health care facilities. PLHIV organizations have focus training to address self-stigma within the population.

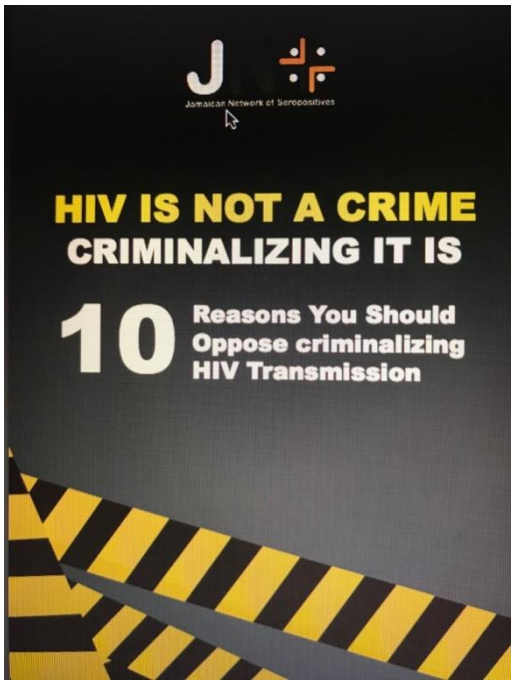
Following continued advocacy by JN+, JASL, JFJ, UNJT and many other partners, a Joint Select Committee of Parliament produced the report of the review of four (4) Acts; the Sexual Offences Act, Offences Against the Person Act, Domestic Violence Act and the Child Care and Protection Act. The report contained positive recommendations for legislative and policy reform that will improve administration of justice and promotion and protection of human rights of all Jamaicans including children, women, elderly and persons with disabilities.

On the other hand, the report did not incorporate all of the recommendations submitted by the civil society, UNJT and other partners including the use of gender neutral language across Acts, expansion of the definition of rape, to include anal penetration, and a review of clauses related to abortion, sex work and same-sex relations.

3.8.2 Motion against the adoption of law to criminalize wilful HIV transmission in Jamaica

Receiving immense debate, The Joint Select Committee made a recommendation for an amendment to the Offences against the Person Act (OAPA) to make it a criminal offence for an individual to “wilfully or recklessly infect a partner with any sexual transmissible disease that can inflict serious bodily harm to that partner”. The JSC notably cited HIV as an example in its statements. This recommendation for legislative amendment is currently being considered in the House of Parliament. In the report, the Committee acknowledged that there was a deficiency in the law in relation to the deliberate or intentional spreading of HIV and other sexually transmission diseases.

Responding to the JSC’s recommendation, Jamaica AIDS Support for Life (JASL) has pointed out, that this law would likely increase the stigma and discrimination against Persons Living with HIV (PLHIV) as it is directly targeting this population. The average person will not stop to think about the real meaning and purpose of the law and will simply reduce it to HIV positive status being made a crime, and so PLHIV will be viewed as criminals. Additionally, the law runs the risk of deterring the general population from getting tested, because persons will be conscious of the fact that a valid defence for transmitting HIV is ignorance of their status.



JN+ brochure produced to advocate against criminalising HIV in Jamaica.

The submitted motion urged the government to include civil society organizations working with a mandate to advocate on behalf of PLHIV, such as JN+ and JASL, human rights groups and representatives from the community of people living with and affected by HIV

in all decision-making processes surrounding the development of HIV-related laws and policies. We reiterate that people living with and affected by HIV must be central in all policy making processes that will impact their lives and livelihoods.

The motion supports the recommendation of the Committee to encourage the implementation of human rights based, non-discriminatory prevention strategies in the HIV response to reduce the HIV epidemic. However, it is believed that this should include increasing the number and range of opportunities for campaigns and programmes in a variety of settings aimed at educating the general public about HIV. These should be held in high schools, colleges and universities, community centres, hospitals, free clinics and town squares across the country.

3.8.3 Rights-based Approach and Transgender People

There were several initiatives to strengthen the positions of key populations to promote a rights-based approach to policies and programming. These include a Jamaica Network of Seropositive (JN+) Strategic Plan to advance PHDP in the national response. The UNJT also supported TransWave Jamaica to host the first Transgender health and wellness conference as part of the commemoration of the International Day against Homo- and trans-phobia. The Conference, which included health care providers in public and private sectors, elevated the national dialogue on issues affecting the human rights and wellness of Trans people. Collaborations forged with the Ministry of Health, Regional Health Authorities and the Jamaica National Family Planning Board along with allied NGOs lead to the application of the 6 modules of the Sex Worker Implementation Tool (SWIT) and the Trans Implementation Tool (TransIT) in programme development, implementation and monitoring.

3.8.4 Prevalence of recent intimate partner violence

Over 138 girls and young women living with HIV and/or survivors of sexual violence accessed psycho-social services and peer support through collaboration between the

UNJT and Civil Society. The girls also received professional one-on-one and group counselling to address trauma and improve their coping skills. Of the 138 engaged, 68% have been retained in care in the public health system of which, 32% have achieved viral suppression. In Jamaica, intimate partner violence prevalence represents 27.8%.

3.8.5 Trained health care workers to identify signs of violence against women and girls in the clinical setting

In 2018, the NFPB commissioned two workshops to build the capacity of sixty (60) front line health care workers. This initiative was aimed at improving their knowledge base of GBV, as well as their ability to undertake advocacy and policy dialogue through their adoption of human rights and gender sensitive approaches to health care delivery. The health care setting is sometimes the first point of contact for survivors of GBV, as such health care professionals are in a strategic position to identify persons who have experienced and/or are at risk of experiencing violence.

3.8.6 Compassionate Care Policy

The Ministry of Health has adopted a Compassionate Care Policy to be implemented in all health care settings. Although not specially focused towards PLHIV, this policy is another strategy implemented within health care settings that seeks to protect all people irrespective of who they are and how they identify.

In 2016-2017, the outpouring of public cries concerning the real or perceived sub-standard treatment meted out to patients/users of the public health system has not gone unchecked. The result has necessitated the development and implementation of strategies to improve the way in which care and services are delivered by the Ministry of Health (MOH). The MOH recognizes that it is critical to ensure that health care staff possess the technical skills and competence to deliver care. Importantly, quality health care seeks to ensure improvement across all levels of the health sector, and equally as important, that care and services are delivered to patients with compassion.

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

3.9.1 Young people: knowledge about HIV prevention

Consistently, through UNICEF, MOE and CSOs engaged representation by and consideration of young people in the national HIV response was forefront. However, with forethought and the adoption of the UNAIDS/UNICEF*ALL In* initiative, the Ministry of Health created the Adolescent Health component, the newest arm of the National HIV/STI Programme. Guided by the Adolescent Technical Working Group (YATWG) (viewed in the picture below) and the Adolescent Policy Working Group (APWG), the Working Groups' specific goal is to reduce AIDS related deaths and new HIV infections among adolescents.

Members of the Youth and Adolescent Technical Working Group

3.10 Teen Hub- Half Way Tree (Kingston) Transport Centre

Responding to reports of negative behaviours such as violence, truancy and risky sexual behaviours of adolescents at the Transport Centre in Half Way Tree, Kingston, steps were

taken to create an inclusive and safe space for young people to access services such as HIV and Syphilis testing and prevention-risk reduction interventions. The Teen Hub opened its doors to adolescents and youths in May 2017. Innovative, non-traditional methods were used to increase access for young people, including weekend and after school offerings and utilizing the population, location approach. Interventions at the Teen Hub are implemented through the collaborative efforts of the HIV/STI/Tb Unit and the Family Health Unit.

Minister of Health Hon. Dr. Christopher Tufton (centre) and State Minister in the Ministry of Education, Youth and Information, Hon. Floyd Green (right), cut the ribbon to open the 'Teen Hub' in the Half Way Tree Transport Centre, St. Andrew

Rapid services on offer include HIV and Syphilis testing, SRH services, mental health screening, career guidance, counselling, family planning counselling and referrals, dispute resolution services to reduce violence and wrap sessions for youth over the 16 years. Services are offered by trained professionals. Between May and December 2017, a total of 2,665 young people visited the Hub, with 657 HIV tests completed by the National Family Planning Board and Civil Society Partners. In 2018, 5,000 adolescents and youth accessed sexual and reproductive health and mental health services at the Teen Hub. Importantly, in 2018, 800 adolescents and youth (males – 438, females – 352) who were not aware of their HIV status were accessed at the Hub. Other services include mental health screening.

3.11 Health and Family Life Education (HFLE) programme in Schools

The Health and Family Life Education (HFLE) programme implemented through the Ministry of Education is a tremendous modality of transferring and providing updated information about SRH including HIV.

In 2018, approximately 84% of secondary schools achieved full or partial HFLE compliance. The MOE through dedicated staff steadily increased school compliance through a number of initiatives. Key among them was the ability for secondary schools to apply for exclusive contracted HFLE teachers. This was made possible through the National Coordinator for HFLE HIV/AIDS Education. This approach has enabled the transition of formally non-compliant schools to achieving compliant statuses in their timetabling, planning and delivery of Health and Family Life Education.

Additionally, the national HFLE programme was bolstered with 14 Youth Behaviour Change Communication (BCC) multimedia products to be included in a social media adolescent sexual and reproductive health (ASRH) campaign. To support this effort, 90 education technicians from the Ministry of Education were also trained and certified in life skills education principles and techniques. Ensuring continuous and complete implementation of HFLE in schools is a heavy lift. Consistent and structured monitoring is necessary in the midst of teacher turn over, change in academic timetables, and the growing need for HFLE teacher training across the six (6) educational regions.

3.12 Adolescent Standards and Criteria

In 2018, there was rollout of the Adolescent Standards and Criteria in each health region (Cycle 2). This initiative linked the 2015 approval of the ten (10) Adolescent Quality Standards and related criteria by the Ministry of Health following the pilot test in seven sites. Cycle 1 was primarily implemented in two health centres that have served as a demonstration project. Table 15 provides information on each of the facilities selected to

participate in the Cycle 2 rollout in the four health regions. Projections for this initiative would result in an additional 9 health facilities introduced and implementing the quality standards for adolescent health, resulting in a grand total of 18adolescent friendly health facilities island-wide.

Table 15: Health Facilities Selected in Cycle 2 of the Rollout of Adolescent Health Standards

Health Region	Health Facility		
	Number Selected	Name	Type
North East (NERHA)	2	Annotto Bay HC	III
		Port Antonio HC	IV
South East (SERHA)	3	Comprehensive HC	V
		Edna Manley HC	III
		Morant Bay HC	IV
Southern (SRHA)	2	Christiana HC	III
		May Pen HC	III
Western (WRHA)	2	Albert Town HC	III
		Darliston HC	III

Source: NHP Annual Report, 2017.

To support this expanded rollout, a series of capacity building workshops took place in 2018. Of note, was collaboration between the Adolescent Health Unit and the HIV *ALL In* initiative of the Ministry of Health. Financial and technical support for the workshops was provided by PEPFAR/USAID, PAHO and UNICEF.

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

3.13.1 Mainstreaming Positive Health Dignity and Prevention (PHDP) in the national HIV/AIDS response

With support from the USAID PEPFAR grant, the NFPB commissioned the development of a PHDP framework including a national strategy to target, among other results, revitalized PLHIV-led initiatives for national impact. The PHDP framework and strategy is integral to the integrated SRH and HIV response as it seeks to improve the health systems through addressing social justice issues of women, adolescents and other key affected populations.

3.14 COMMITMENT 7: Ensure that at least 30% of all service delivery is community-led by 2020

3.15 Civil Society Interventions and Best Practices

Civil society organizations are equal partners in the National HIV response. Demonstrated by their strength in advocacy and passion in programme delivery, CSOs reach people living with HIV, at high risk of and affected by HIV with a package of interventions and support services. This section features a select number of CSOs and the tremendous work being done to end AIDS in Jamaica.

3.16 Jamaica Community of Positive Women (JCW+)

The Jamaica Community of Positive Women (JCW+) exists for the purpose of ensuring that Women Living with HIV (WHIV) in all their diversity, affected children and young people have access to information, health and social services and to strengthen the enabling environment for personal development and leadership capacity; in their stride to reach their full potential and be recognized as productive citizens. For the period 2014 - 2018 JCW+ focused on leadership development, systems strengthening, advocacy related to sexual reproductive health and rights, ending violence against women and building partnerships for reach and sustainability.

3.16.1.1 Action Plan

An action plan developed in 2018, allowed participants to propose areas for focus and collaboration for further growth in 2019. Key advocacy areas identified included, Sexual and Reproductive Health Rights, Anti-Discrimination Law, and Gender Based Violence. Below is a summary of the action plan.

Goals	What	Input	When	Outcome
Goal #1 - Reduce Stigma and Discrimination	Advocacy- Sensitization around the anti-discrimination law OSHA Increased awareness and education of HIV & HIV related Stigma & Discrimination Host 8 interventions to train 20 WHIV about HIV in the context of human rights		March - October	Increased awareness of the need for policy/law Increased awareness of HIV related S&D
Goal #2 - WHIV can access their Sexual and Reproductive Health Rights	Condom distribution at targeted events and locations 10 boxes per Month Educate 50 WHIV on family planning, SRHR PMTCT Sensitize and enlist partners who provide health or social services to support WHIV treatment and care	Admin: transport	By October 2019 By March 2019	2 case of 50 per case x 144 per box (FamPlan) 3 workshops held with 15-20 participants per Qtr. 2 for 18-35 yo 1 for >36 yo Establish referral system with health and service providers. Data from partners used to support 50 women to achieve viral suppression
Goal #3 - Advocate to end Gender Based Violence and increase knowledge	Conduct Orange Day activity Partners participate in government and CSO activities		Monthly (25th) Ongoing	160 persons reached per month JCW+ participants/partners registering and participating
Goal #4 - Advocate for changes to laws and policies that infringe on the rights of WHIV eg. Sexual Offences Act	Lobby the government e.g. Send petitions Continue to partner with and support other CSO initiatives		Ongoing Ongoing	Laws and policies amended as per recommendations
Goal #5 - Commitment to service	Provide incentives for persons who arrive to meetings early/on time; Draft circulate and enforce guidelines and repercussions for		Ongoing Ongoing	1-5 participants receive incentives for arriving early at each meeting or intervention.

Goals	What	Input	When	Outcome
	participants who arrive late to events			
Goal #6 - Build up JCW+ to provide efficient communication, planning, implementation and capacity building	Train staff in communication strategies, and planning Identify a core set of women who are leaders to assist with initiatives and mentoring the younger participants		December 2019	Staff trained in communication strategies, and planning 5-8 women leaders identified 5-8 leaders mentoring 1 younger participant each
Goal #7 - Increased funding and resource mobilization	Write proposals to secure funding Brainstorm fundraisers		By December 2019	Proposals written Fundraisers held Funding secured for JCW+ activities

Source: JCW+ Year-End Assessment, 2019

3.17 Jamaica AIDS Support for Life (JASL)

Jamaica AIDS Support for Life shares two abstracts demonstrating successful interventions through their work with PLHIV and MSM. Their best practices have garnered not only national but also regional and international attention.

3.17.1 Enhanced Adherence Intervention Programme for People Living with HIV (PLHIV) Supports Viral Suppression in Jamaica

Learning Objectives

This session sought to enable participants to be able to identify and adopt strategic approaches to support clients to achieve viral suppression.

Background

In January 2018, Jamaica AIDS Support for Life's (JASL) Kingston clinic recognised that a number of its PLHIV clients who were enrolled for ≥ 2 years had never received a viral load result of <1000mL copies. A number of these clients did not consistently maintain their appointments, were lost to follow-up, or articulated issues with adherence.

Programme Design

The Enhanced Adherence Intervention Programme (EAIP) was created by the members of the treatment and care team comprising a medical director, case manager, nurse, psychologist, social worker and adherence counsellor to address challenges related to adherence. Its objectives were to improve client adherence, motivation and self-efficacy in order for the PLHIV to achieve viral suppression. Cases were identified through treatment database analysis and case conferencing. The care team used a number of tools to assess clients' treatment readiness, nutritional needs, and psychosocial needs. Customised treatment and service plans were developed with each client based on JASL and client inputs and implemented with each client for 3 months, after which the viral loads were tested. Selected clients received support for medication pick up and bi-weekly pill count; participated in support groups and treatment literacy workshops with their

caregivers; and were referred to other relevant specialists, such as a psychiatrist, as needed. Clients received, where needed, pill holders, Medi-Safe App, care packages, travel stipend and supermarket vouchers for three months.

Results and Lessons Learnt.

The programme fostered greater cohesion among the treatment team to address each client and built a stronger support system with clients and caregivers. Over the course of engagement (January to November 2018), the clients became more empowered and showed greater independence in their keeping of appointments. Of the 80 who participated in the programme in 2018, 66 (82.5%) achieved viral suppression, thus resulting in the further improvement of the JASL treatment cascade. Suppressed clients reverted to the JASL comprehensive health and case management and unsuppressed clients continued under EAIP.

Conclusion and Next steps

The client-centred EAIP programme has since been expanded to all JASL clinics. The programme has since been identified by the Ministry of Health as a best practice and was shared with the National HIV Programme at its annual planning retreat. A number of public clinics have since indicated their adaptation of the programme.

Jamaica AIDS Support for Life: Christina Gordon, Jennifer Brown-Tomlinson, Xavier Biggs and Kandasi Levermore

3.17.2 Anal Care Services Critical Component in Clinical Care of Men Who Have Sex with Men in Jamaica

Learning Objectives: This session sought to enable participants to be able to recognise the need for anal care services for men who have sex with men (MSM) and ascertain the required steps to offer anal care services as part of a comprehensive clinical programme.

Background

Men who have sex with men are at high risk for contracting Human Papilloma Virus (HPV), which can cause anogenital warts and certain types of anal cancers in addition to other sexually transmitted infections (STIs), such as HIV via the anus. In February 2018, Jamaica AIDS Support for Life (JASL)'s Kingston clinic had 152 HIV-positive and 114 HIV-negative MSM on register. A number of MSM were noted to have anogenital warts and were referred to private physicians for treatment; however, the cost of the services was a barrier for clients.

Programme Design

International Training and Education Centre for Health (ITECH) provided technical assistance to JASL through an organisational capacity assessment and the findings were used to inform training to the JASL clinicians and nurses. Areas covered were proper screening and physical examination techniques for MSM and transgender and identifying at-risk patients and treatment modalities for common anogenital conditions. JASL procured the necessary medical equipment and medication. A special clinic was established with a dermatologist for a six-month period to treat clients who were diagnosed with anogenital lesions. Routine screening and physical examination were included in the HIV/STI clinics.

Results and Lessons Learnt.

Between January and November 2018, 114 MSM (82 HIV-positive and 32 HIV-negative) received routine anal inspections and digital rectal examinations, while 6 declined. 42 MSM were treated for anal lesions with cases resolved after three or four treatments. Two known cases of recurrence have since been resolved. Podophyllin, the drug currently used for treatment is being phased out based on its high toxicity levels and its availability is decreasing. An alternative treatment, Trichloracetic acid (TCAA), is being sought to maintain the treatment being provided.

Anoscopy was done with five clients with anal lesions which required surgical excision, but few specialists are comfortable with the procedure and none was available to the

organisation. These clients were referred to the surgical clinics in 2 public hospitals. However, the clients are yet to undergo the recommended procedure.

Conclusion and Next steps

Uptake of anal care services at JASL indicates there is a need for these types of services for the MSM community. Currently, all MSM in JASL clinics are screened for anogenital issues. However, treatment services are not widely available. Efforts are needed to sensitise dermatologists and HIV care providers of the need for the services. Prevention and risk reduction messages must include education about anogenital STIs and staff need training to include this as part of their routine prevention messaging for MSM.

Jamaica AIDS Support for Life: Jennifer Brown-Tomlinson, Yanique Williams, Xavier Biggs and Kandasi Levermore.

3.18 Jamaica Network of Seropositives (JN+)

Jamaican Network of Seropositives represents a family of people who come together from all walks of life – students, teachers, farmers, chefs, knitters, maintenance workers, counsellors, entrepreneurs, and many more. JN+ aspire, dream and support each other to create a better tomorrow. As a network, their mandate is to advocate for the rights and concerns of people living with and affected by HIV and AIDS, through partnership, empowerment and resource mobilisation.

The Network was established in 1996 following the first regional meeting of People Living with HIV/AIDS in Trinidad. This meeting was sponsored by the World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the Global Network of People Living with HIV (GNP+) and the International Community of Women Living with HIV/AIDS (ICW). In 1997, JN+ was publicly launched with support from the National HIV/STD Control and Prevention Programme (NHCP) and the Caribbean Epidemiology Centre (CAREC).

3.18.1 JN+ Best Practices

Support Groups: "Our support groups have been around since the establishment of JN+ in 1997 seeing members coming together to share their challenges, issues and concerns around surviving and access to medication. These groups are still used as a medium to empower People living with HIV (PLHIV), providing Capacity Building, Advocacy and Skills-based Trainings. Members also identify it has an avenue to meet and socialize with other from the community regarding adherence, survival, accessing treatment and care. Since its inception members of our support groups have seen improvements in their lives who are currently working within the HIV response; employed to private and public sector organizations; reaching viral suppression and many expressed that they have become self-sufficient. Moreover, our support group members have benefited from trips outside of the regular meeting setting to beaches and rural areas. Many highlighted that these experiences have drawn them closer to the organization and feel a sense of belongingness. It should not be forgotten that one of our main achievements is the

availability of antiretroviral (ARV) medication for PLHIV within the country as in the early stages PLHIV were given Bactrim. However, through advocacy and constant agitation, we have collaborated with others civil society organizations were able to get the Ministry of Health to purchase ARVs for the community, thus seeing a reduction in HIV-related deaths".

Positive Health, Dignity and Prevention & Treatment Literacy Trainings/Sessions: "Members from the PLHIV community have benefited from PHDP and TL trainings and sessions. Many of our members are fully trained in all seventeen (17) modules including Treatment Literacy, Stigma and Discrimination, HIV/AIDS Basic Facts, Self-care and Levels of Disclosure. Their capacity building has resulted in significantly benefits. Benefits include working within the HIV response as Community Facilitators, Redress Officers and Adherence Counsellors, who are currently assisting other PLHIV to start ART, return to care and or remain in care to achieve viral suppression. We have seen a lot of progress and positive feedback from these individuals who are contributing to the National Treatment Cascade in relation to achieving the 90-90-90 targets. The PHDP trainings/sessions have foster positive changes with others as they have illustrated vast improvement in regard to their treatment. Many have become more empowered and self-sufficient; advancing their studies; becoming more confident when communicating with healthcare providers; more knowledgeable of the different lines of medication available in Jamaica, their appropriate substitutes and how to mitigate side effects.

After the Treatment Literacy Trainings, a member of JN+ contact participants to check-in with them on a bi-weekly basis to ascertain information regarding their treatment, care and support. Through the check-ins participants are encouraged to stay in care, communicate more with their healthcare provider, seek assistance, information and support from their treatment sites such as the Social Worker, Adherence Counsellor and Psychologist. It is be noted that participants are also referred for additional services such as legal representation in cases of HIV-related discrimination; linked to a treatment site; getting care packages such as grocery vouchers and stipend when they visit their treatment sites. Ultimately, we are able to provide a track record of participants' Antiretroviral Treatment (ART)".

Jamaica Anti-discrimination System for HIV (JADS): "This is the premier system where persons are able to report HIV-related discrimination in Jamaica. It collects complaints and provide redress options for clients in the form of legal representation, social and psychosocial services, linked to treatment and care, and community interventions. JADS is guided by a Steering Committee and Case Review Panel consisting of multisector organizations that have a mandate to provide redress and is governed by a Confidentiality Policy. Some of the stakeholders include the Client Complaint Mechanism of the Ministry of Health, the National Family Planning Board, Jamaica Constabulary Force (JCF), Jamaicans for Justice (JFJ), and the Pharmacy Council. Each case is given a unique case number. We have observed an increase in reporting and redress of HIV-related discrimination where persons are accessing the system through the treatment sites, social media, telephone conversations, Community Facilitators and Redress Officers".

Liaising with PLHIV Pharmacies: "By way of constant dialogue and communication we are able to identify when there is limited or no ARV available at pharmacies that dispense ARV. In some instances where the prescribed medications are not available, we help to advocate for appropriate substitutes. Consequently, we are able to communicate this information to our membership and the PLHIV community at large. Notwithstanding, we have advocated in the past to the Ministry of Health to investigate the unavailability of medication at pharmacies and or treatment sites. Currently, we have seen where this has proven to be very effective to reduce ARV stock out among pharmacies across the island. Additionally, we have built a relationship with the pharmacies and have identified opportunities to educate and share information about JN+, JADS and our activities. This can be cited through attendance at our activities including the World AIDS Day Breakfast Forum and invitation to make presentation on JN+ and JADS".

3.19 Eve for Life

Ever for Life works diligently to improve the sexual and reproductive health and rights, and quality of life, of young women and girls exposed to HIV and sexual and gender-based violence. The organization is all embracing and is highly featured as a stellar CSO in the HIV response.

3.19.1 Best Practices

Core Indicator for Global AIDS Response Progress Reporting	Ensure that at least 30% of all service delivery is community-led by 2020
Organization	EVE for Life
Name of Project	I AM ALIVE Programme

Programme Design	The IAA programme applied an adolescent centred empowerment model in which pregnant adolescents and adolescents living with HIV (ALHIV) who attended Ministry of Health (MoH) facilities for antenatal care or for HIV treatment and care were referred to the IAA programme by adherence counsellors or social workers employed to the pMTCT programme. After a thorough needs assessment, the new client was registered in the IAA programme where she would receive psychosocial services, sexual and reproductive health education, life skills education, mentorship (including peer mentorship) and one year of material support in the form of a care package. One approach that makes IAA unique is that the core of the support team is comprised of older women living with HIV trained to become 'Life Coaches', and programme 'graduates' trained to function as 'mentor moms'. The support provided was expected to assure adherence among young mothers and ensure they remained in the pMTCT programme. The mentor mom initiative is designed to mitigate the impact of the epidemic on teenage and young mothers living with HIV. The programme provides comprehensive information and training in SRH and rights including HIV, lifeskills, advocacy, HIV group education, peer education and case management to groups often age and young mothers living with HIV aged 14- Once qualified to provide mentorship, the young mothers are assigned to select health facilities, under guidance from an eMTCT nurse and a Mentor Mom Coordinator. The programme design sought to assure that each enrolee (referred to as mentee) had access to a Mentor Mom - with each Mentor Mom (MM)being assignedbetween4–5menteesatatime.MMare tasked with providing ongoing support to mentees and the peer mentorship provided by Mentor moms, programme participants learnt to manage stigma and discrimination they encountered at home, in their communities and in the health centres and to cope with their HIV status. Mentees are also provided with lifeskills training,

	training in parenting and coping strategies to improve their overall health outcomes.

Timeline	2017-2018
Name of Funder(s)	Global Fund and UNICEF
Beneficiaries	Teen HIV positive mothers
Project Objectives	The "I Am Alive" programme, has four main aims. The programme was expected to: 1. Increase knowledge on comprehensive sexuality education, including skills-based, HIV and pregnancy prevention education among beneficiaries; 2. Improve service delivery in the elimination of mother to child transmission (pMTCT) programme through the establishment of two centres of excellence in adolescent sexual and reproductive health; 3. A) Improve adherenceandfollowupof100 mothers in the pMTCT programme through peer mentorship; and b) Improve knowledge and awareness of HIV and pregnancy prevention among 600 teenage mothers who attend maternal and child health facilities in St. Ann and St. James 4. Improve the quality of life of 40 adolescent mothers to support positive prevention and adherence through income generating and livelihood activities.
Outcomes/Outputs	• The programme reached 103 adolescents; 39 adolescents graduated and 5 of a projected 9 mentor moms were deployed. • Knowledge levels on sexual and reproductive health (SRH) issues improved among the programme's primary beneficiaries. • Contraceptive use at baseline was reported by 78% of the sample compared to 81% at end line. • 90% of the base line survey sample reported condom use at most recent sexual intercourse; compared to 95% of the end line survey sample. • Programme participants experienced an improved quality of life. • The programme was effective in helping participants build self-worth, over-come fear of their HIV status and to accept their reality, helped in changing their negative attitudes towards the pMTCT programme and

	improved the irrelationships with their children and their partners/spouses. Health care providers trained by EFL reported improved knowledge of how to care for adolescents as well as their attitudes toward adolescent clients. They admit needing additional training in communicating with the adolescent as well as in case management.
Evaluation/Results	**Main Evaluation Findings:** The findings of the evaluation provide evidence that it is possible for adolescents who have been traumatised by sexual violence, HIV infection and related stigma and discrimination and too early childbearing can, with supportive counselling, education and positive mentorship, become self-confident and self-aware individuals. As with other effective adolescent-focused programmes, effectiveness comes at a high financial cost.
Lessons Learned	The programme will need to expand its transition efforts to encourage and prepare women for transition to job readiness and full womanhood through scholarships and partnerships with existing job training programmes. ▪ The evaluation data indicates that there is a proportion of adolescent mothers living with HIV who are not complying with the Ministry of Health directive to only feed their children with the supplemental feed provided by the Ministry of Health and are mixing breast feed with bottle feed. This practice places the child at risk. Non-disclosure of HIV status is a barrier to effective outreach and in-reach.

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

3.21 Total HIV expenditure

Jamaica tracks HIV related expenditure as part of its national planning and accountability mechanism. Since 2009, the country has utilized the UNAIDS National AIDS Spending Assessment (NASA), which is a comprehensive and systematic methodology used to determine the flow of resources from their origin to service delivery among the different institutions dedicated to ending the HIV epidemic using the bottom-up, top-down approach. The latest NASA exercise covers 2015/16 and 2016/17. The exercise achieved 80 percent response rate, through the collaborative support of government, civil society, academia and International Development Partners (IDPs); including the UNJT.

3.21.1 Overview of NASA 2015/16 and 2016/17

Spurred by Jamaica's reclassification as an upper middle-income country by the World Bank, Jamaica's ability to qualify for international aid has been restricted. Financial sustainability and diversification of funding sources has not only become an imperative for the national HIV response but an absolute necessity for other national initiatives.

Notwithstanding GOJ contribution, the NASA report notes that expenditure on health in Jamaica is supplemented by a few notable International Development Partners (IDPs), namely PAHO, USAID/PEPFAR, IADB, UNICEF, GFATM and UNAIDS. These partners are key stakeholders in the national response to end AIDS and to improve the lives of people living with and affected by HIV.

Table 16: Expenditure by Funding Source

Source Name	2015/16 USD	%	2016/17 USD	%
Public	$6,950,001	**39**	$6,345,447	**35.5%**
Private	$1,731,782	**9.7**	1,629,352	**9.1%**
International	$9,146,659	**51.3**	9,891,106	**55.3**
Total	**$17,828,442**	**100**	**$17,865,905**	**100%**

Source: National AIDS Spending Assessment, 2015-2017

Incrementally, Government of Jamaica has increased its financial contribution to ending HIV and achieving the 90-90-90 targets by 2020. The 2013/14 NASA report assessed an average GOJ contribution of 30%. However, with reference to Table 16, GOJ averaged 39% and 35.5% expenditure for the years 2015/16 and 2016/17 respectively.

According to Table 16, total HIV expenditure for fiscal years 2015/16 and 2016/17 averaged just under $18 million dollars (US). Expenditure shows a steady implementation response over both years. After decades of work, the steady expenditure may be reminiscent of streamlined data-driven responses to upend the epidemic concurrently in both key populations and within the general population.

Treatment and Care accounted for approximately 21.4% and 31.9% of GOJ expenditure for the years 2015/16 and 2016/17 respectively (Table 16). GOJ accounted for more than 63% of Treatment expenditure in 2015/16 and 64% in the 2016/17 period. Explicitly, GOJ

assumes the weight of Treatment and Care components of the national HIV response. Even more pronounced in Table 17, GOJ financial support of 43.9% and 44.8% for Programme Coordination, Planning and Management (PCPM), the circuitry of all HIV response operations in 2015/16 and 2016/17, respectively.

Table 17: Expenditure by AIDS Spending Categories

	2015/16			2016/17		
AIDS Spending Categories	**GOJ Expenditure (USD)**	**% of GOJ Exp.**	**% of Total Exp. ASC**	**GOJ Expenditure (USD)**	**% of GOJ Exp.**	**% of Total Exp. on ASC**
Prevention	$2,282,679.27	32.84	39.44	$1,549,051.03	24.41%	31.38
Treatment/Care	$1,486,222.60	21.38	63.32	$2,025,304	31.92%	64.42
OVC				$360.80	0.01%	5.3
PCPM	$3,056,452.62	43.97	43.11	$2,843,194.72	44.81%	31.69
Training	$2,525.89	0.03	0.15			
Social Protection	0	0	0	0	0	0
Advocacy	$122,120.51	1.75	15.25	$114,556.60	1.81%	15.74
Research						

Source: National AIDS Spending Assessment, 2015-2017

3.22 Expenditure on cash transfers for young women and girls

The Government of Jamaica through its social and protection programmes do support young women and girls. Primarily through the Programme of Advancement Through Health and Education (PATH) administered by the Ministry of Labour and Social Security (MLSS), PATH provides cash transfers to persons within families assessed as poor and vulnerable. Young women who are pregnant and lactating within eligible families receive bimonthly cash grants of $3,200.00 (JMD). Adolescent girls enrolled in secondary school receive payments tiered by grade level. Girls in grades 7-9 (lower secondary school) receive bimonthly cash grants of $3,600.00 (JMD). Girls enrolled in grades 10-13 (upper secondary school) receive bimonthly cash grants of $ 4, 200.00 (JMD).

Payments to students, pregnant and lactating women are contingent on their compliance with the established conditionalities within PATH. For example, compliance for pregnant and lactating women requires bimonthly visits to a health clinic while compliance for students requires minimum school attendance of 85% of the days that school is in session.

As a collaborative partner, World Bank support resulted in improved retention of students in school and provided better employability perspectives for young people. By providing direct grants for children and young people up to 19 years old, the project emphasized on development of children and adolescents and increasing their education and health outcomes, including reduction of behaviours that increase risks for HIV transmission. Entrepreneurship grants and skills training were provided to 1,200 beneficiaries. At secondary level, net change in school attendance was an additional 0.5 days compared to a control group. Net change in secondary school completion rate was 50%, surpassing the end target of 8%. The government continues to invest in social protection initiatives to reduce vulnerabilities (HIV/AIDS) among women and girls in Jamaica.

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

3.23.1 Human Rights Baseline Assessment

Jamaica is one of twenty (20) priority countries to benefit from the Global Fund's ***"Breaking the Barriers"*** initiative aimed at undertaking comprehensive interventions to significantly reduce human rights barriers to health. In operationalising the initiative, a baseline assessment as well as key stakeholder consultations were conducted between October 2017 and August 2018 to provide the country with the requisite data to inform the human rights programme development and implementation.

3.23.2 Jamaica Anti-Discrimination System for HIV (JADS)

The Jamaican Anti-Discrimination (JADS), formerly the National HIV-Related Discrimination Reporting and Redress System (NHDRRS), is a system that collects and investigates complaints of HIV-related discrimination across Jamaica and refers them to the appropriate entities for redress. The first complaint was documented through JN+ in 2005, but the NHDRRS was formally established in 2007 with funding from USAID and the Ministry of Health. The Jamaica Anti-Discrimination System was launched on November 10, 2017 subsequent to a competition led by The Jamaican Network of Seropositives and the NHDRRS Steering Committee. The Jamaican Anti-Discrimination System is guided by an Advisory Group consisting of multisectoral partners, JN+ coordinates JADS with financial and technical support from the Enabling Environment & Human Rights Unit of the National Family Planning Board (NFPB).

As part of efforts to increase the uptake of redress services provided by the **Jamaica Anti-Discrimination System (JADS)** for HIV and similar mechanisms, JN+ and NFBP collaborated to host four (4) regional sensitisation workshops were held with 154 multi-sector partners. An outcome was the directory of redress services (**The Jamaica Anti-Discrimination Reporting and Redress Directory**) that was created and published for

sector-wide dissemination. The Jamaica Anti-Discrimination System (for HIV) JADS collects cases of HIV-related discrimination and gender-based violence and refers them to the appropriate entities for redress. Table 18 provides cases submitted to JADS in 2018.

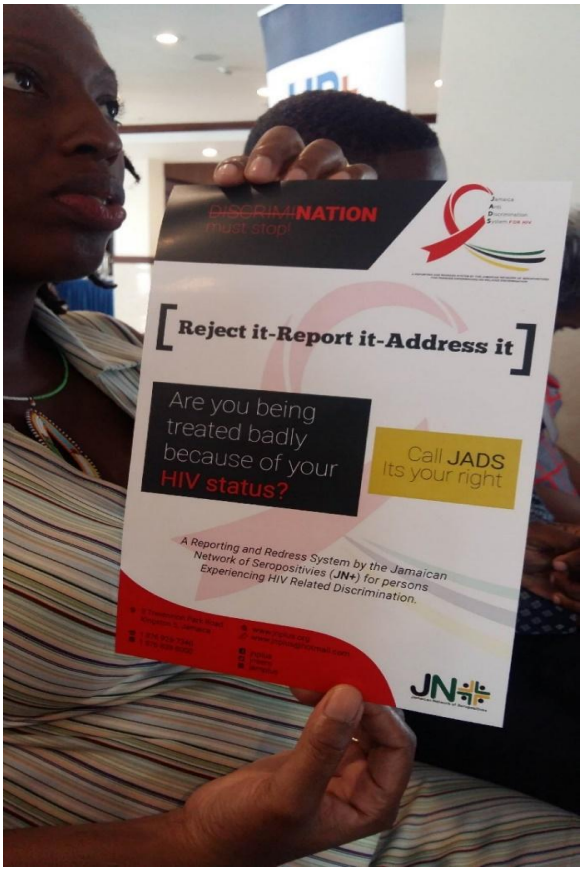
Table 18: JAMAICA ANTIDISCRIMINATION STSTEM FOR HIV CASES FOR JANUARY–DECEMBER 2018

Case #	AGE	DATE	GENDER	PARISH	SETTING OF INCIDENTS	NATURE OF MISTREATMENT
328	N/A	8/01/18	Female	St Catherine	Workplace	Breach of Confidentiality
329	32	24/01/18	Female	Kingston	Health Facility	
330	28	16/01/18	Female	St James	Health Facility: Government Hospital Community	Breach of Confidentiality
331	23	26/01/2018	Male	West-moreland	Community	Mistreatment/ Violence: Harassed/Verbally Abused
332	39	13/02/2018	Female	Kingston	Workplace: Private Company/Business	Breach of Confidentiality
333	43	5/03/2018	Female	St Mary	Community: High Gate	Mistreatment / Violence: Forced to leave the community
334	25	6/03/2018	Male	Kingston	Community: Mountain View	Harassed/verbally Abuse
335	23	13/03/2018	Female	St Elizabeth	Health Facility: Government Hospital	Discrimination with in Hospital
336	25	21/03/2018	Female	St Catherine	Health Facility: Government Hospital	Poor Medical Treatment
337	26	22/03/2108	Male	Clarendon	Workplace: Government Entity	Mistreatment/Violence: Physical Attack
338	26	21/03/2018	Transgender	Kingston	Community	Denied Services: Poor Customer Service

339	46	10/04/2018	Male	St Mary	Workplace: Private Company	Mistreatment/Violence: Harassed/Verbally Abused
340	27	12/04/2018	Transgender Female	St Ann		
341	22	21/02/2018	Female	Hanover	Community	Breach of Confidentiality: Information was shared without prior knowledge or consent
342	21	17/04/2018	Male	Kingston	Community	Mistreatment/Violence: Harassed Verbally abused
343						
344	22	15/05/2018	Male	St Andrew	Community	Mistreatment/Violence: Physical Attack
345	27	9/06/2018	Female	St Thomas	Community	Mistreatment/Violence: Harassed/ Verbally Abused
346		9/06/2018			Community	
347	38	13/06/2018	Female	Kingston	Community	Mistreatment/Violence: Mistreatment of Relative
348	32	2/07/2018	Female	Kingston	Community School	Mistreatment/Violence: Harassed/ Verbally Abused

3.23.3 First HIV-Related Discrimination Case to the Industrial Dispute Tribunal

The first HIV-related discrimination case now awaits the ruling of the Industrial Disputes Tribunal (IDP). The Occupation Safety and Health Department (OSHD) at the MLSS spearheaded a breakthrough by successfully navigating a case of HIV-related unjustifiable dismissal through the Ministry's redress mechanism. After three unsuccessful attempts at conciliation where the Company at one point made an attempt to settle, then withdrew the offer deciding they no longer wished to accept liability, the



matter has been referred to the IDP. On November 6, 2018 the OSHD met with representatives for JASL and JFJ to discuss the case. The complainant was successfully linked to care and receiving treatment while the case awaits a ruling.

3.23.4 Workplace Stigma and Discrimination sessions

The NFPB, the Ministry of Labour and Social Security's HIV Unit and JN+ collaborated on engaging organizations to sensitize staff on stigma and discrimination. Fifteen (15) Companies were selected and agreed to participate in the sessions. The team reviewed national policies and laws protecting PLHIV, includingthe Occupational Safety and Health Bill, the National Workplace Policy on HIV and AIDS, the MLSS Social Protection Programmes, discrimination reporting and redress options, and the Ministry of Health Voluntary Compliance Programme.

3.24 Legal protections for key populations

3.24.1 HIV in the Workplace and Occupational Safety and Health

Jamaica fulfilled its reporting obligations under the **Nursing Personnel Convention, 1977 (N0.149)- Jamaica (Ratification:1984)**, by submitting for review to the ILO's Committee of Experts on the Application of Conventions and Recommendations (CEACR), a copy of the draft Ministry of Health HIV Workplace Policy. The policy offers guidance to health care employees as to how to prevent HIV/AIDS at the workplace and how to cope with persons infected with HIV/AIDS.

The NFPB continued its partnership with the Ministry of Labor and Social Security recognizing that several workplace safety and health concerns, including HIV, require urgent attention. Voluntary compliance programmes, aimed at preparing enterprises for the key requirements under the draft OSH Bill has begun. Five (5) companies successfully benefited from assisted revisions and or development of their Workplace Policies on HIV/AIDS, including sensitization of employees. As part of the VCA programme, rapid assessments, baseline assessments and VCP audits were completed for companies including Scotia Group, National Producers Ltd., Industrial Chemicals Company, The Mustard Seed Community and Trade Winds Citrus.

3.24.2 Development and implementation of policy and protocol on Support Services referral mechanism

Successful consultations to guide the development and implementation of formalized support services referral mechanisms were convened with multi-sector stakeholders, namely the Regional Health Authorities, Ministries, Departments, Agencies, and Civil Society Organisations, inclusive of Faith Based Organisations.

The development and institutionalisation of a formal and effective referral and linkage process will address the gaps identified in the referral process between the Social Support Providers, Civil Society Organisations (CSO) and the formal health system involving the Regional Health Authorities (RHAs). Additionally, CSO linkage and referral process has been considered best practices. Their results have witnessed increased linkage to support and clinical services, improved hand-over to social support providers and increased uptake of HIV and SRH services.

A Referral Directory has been developed as a tool to accompany the referral mechanism. The directory divides the country into sections based on the four Regional Health Authorities in Jamaica: North East Region, South East Region, Southern Region and Western Region. The key shows the colours that represent each region along with the assignment of parishes to each region. Generally, the Referral Directory offers a listing of

all civil society organizations, social support services, health services and legal services available through Public and Civil Society Social Support Organizations and Agencies. The directory arranges the organizations by region, parish, as well as subject areas. It also includes the service agency's address, contact number, fax, opening hours, website, email and importantly, the process to access the service (whether by appointment, walk-in, etc).

3.24.3 Policy Briefs for Advocacy

A Policy Brief addressing *"Recommendations to Address Discrimination based on Health Status with particular Focus on HIV"* was developed by the National Family Planning Board's (NFPB) Legal and Policy Review Committee (LPRC). The document sought to address noticeable gaps in Jamaica's human rights framework.

Targeted stakeholders received the disseminated policy brief, which advocated for the development of comprehensive anti-discrimination legislation and the establishment of a National Human Rights Institute (NHRI). The work was shared among civil society partners, Ministries, Departments and Agencies. Over 100 copies of policy brief were disseminated, inclusive of copies that were shared at the 2018 MOH HIV Annual Review.

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

3.25.1 Co-managing TB and HIV treatment

In 2016, the Tuberculosis prevention and control programme was integrated with the National HIV/STI Programme to form the HIV/STI/Tb Unit. This integration was an effort to improve the efficiency and effectiveness of the Tb programme. Despite this integration, challenges persisted due to lack of adequate staff both in the HSTU and the NSU, which delayed activities associated with the Tb arm of the Programme. To alleviate challenge, in 2017, the HSTU employed additional staff. Key among the staff was a specialist Programme Development Officer, whose tasks included the management of the Tuberculosis component. According to Table 19, increase in case detection was observed, which may be as a result of the expanded Tb programme capacity.

Table 19: Tuberculosis cases in Jamaica 2012-2017

Cases	2012	2013	2014	2015	2016	2017
Number of Tb cases detected	94	96	86	103	103	124
Number screened for HIV	65	95	79	66	56	99
% of Tb cases screened for HIV	69.1	98.9	91.9	64.1	54.4	79.8
Of cases screened, # co-infected	15	16	19	15	28	20
% of cases co-infected	23	16.8	24.1	22.7	50	16.12

Data Source: WHO Global TB Report Jamaica (NHP Annual Report, 2017).

3.25.2 Challenges

In 2017, several major programme challenges were identified. Among areas of challenge were case detection and laboratory testing. Based on the initiatives stated below, coupled with increased collaboration between the HSTU and NSU, there are high expectations to

decrease the incidences of Tb in Jamaica and improve the delivery of service to affected persons and their families.

Initiatives include:

1. Revision of the National Tuberculosis Treatment Manual. This consisted of a series of technical working group meetings involving members with expertise in laboratory and clinical management of Tuberculosis as well as epidemiological and surveillance expertise. These meetings commenced in January 2018.
2. Development of the National Strategic Plan for Tuberculosis 2019-2023. The TGW reviewed this document and commence stakeholder consultations and costing same. A Consultant was recruited, with the assistance of PAHO, and the draft strategic plan was completed in December 2017. The Tb TWG will be tasked with reviewing and finalizing this document.
3. Strengthening the National Public Health Laboratory's capacity in Tuberculosis testing. Smear microscopy was restarted in December 2016. The HSTU with the assistance of the Health Promotion and Prevention Unit, has been procuring GeneXpert cartridges.
4. Development of National treatment and laboratory algorithms. This is in keeping with global standards for Tb diagnosis and treatment, which will build the capacity of HCWs.
5. Improvements in reporting mechanisms and monitoring and evaluation. This will strengthen surveillance and improve the quality of Tb data collected.

3.25.3 Sexually transmitted infections

Not only are STIs such as Syphilis, Gonorrhea, Chlamydia and Trichomonas a global concern, but also a national one. High risk behaviours, including social determinants of health are equally important contributors to persons contracting STIs in our population. A surprising result from the 2012 KABP survey revealed that knowledge of STIs is declining in both sexes, though data reflects relatively stable rates of STIs (Table 20).

Table 20: STIs Reported, 2016 – 2017

Sexually Transmitted Infections	Male		Female	
	2016	**2017**	**2016**	**2017**
Syphilis	482	471	590	566
Chlamydia	567	425	694	575
Genital Discharge Syndrome	7,532	7,581	29,995	28,384
Genital Ulcer Disease	15	0	23	4
Trichomoniasis	15	0	409	544
Genital Warts	440	387	487	463

Source: NHP Annual Report, 2017.

Syndromic management of STIs continued to be the cornerstone of the Jamaican strategy. Robust public health interventions are integrated in the public health system at a primary health care facility. In Jamaica STI treatment is accessible, affordable and appropriate with initiation of treatment at first visit. Whilst capacity building of clinicians for curative services and CIs for partner notification and testing continues to be adequate, growth is needed in the surveillance of STIs as Class 3 Notifiable Diseases and laboratory identification of pathogens. Additionally, further steps are necessary in strengthening the national and sub-national STI programme. Congruently, a recommendation from the *Pan Caribbean Partnership against HIV/AIDS STI Surveillance Report (2012) proposed* the establishment of an STI Technical Working Group (TWG). Further to the recommendation, swift steps were taken to on-board this finding. In 2018, the TWG commences meetings with key stakeholders from the NPHL, ITECH, medical stalwarts in the field of STIs and representatives from PAHO and UCSF.

3.25.4 The Way Forward

Over the next year, and beyond, the TCS Unit is aiming to:

1. Formulate an overarching roadmap for STIs in Jamaica, which considers the current state of affairs, implements recommendations from the 2017 SITAN and determines the most feasible approach for the continued holistic management of STIs. This is

especially needed in the context of syndromic versus case based management. The HSTU will be looking to determine what patterns, from the State of California, which transitioned from syndromic to case-based management of STIs, can be applied in the Jamaican context.

2. Improve capacity building through the retraining of clinicians, FNPs, curative nurses and current CIs in STI management. The continuation of CI training will be made possible by USAID and aims to increase the manpower needed for proper partner notification and testing for HIV and other STIs.
3. Improve visibility of the national STI response via:
    a. Updating of the MOH's website with available STI information.
    b. Linking the NSU database, which is used to report aggregate STI data, to a main server within the HSTU for associated dashboards at a sub-national level.
4. Improve quality data collection of STIs by:
    a. Revamping the use of the STI Clinical Summary Sheet for all patients being treated for a STI at all primary health care facilities.
    b. Engaging the Health Records department to obtain STI data from the MCSR so that it may be triangulated with data received by the NSU from CIs in the field.
    c. Conducting a STI prevalence study at the main STI clinics initially to get a true representation of the burden of STIs in our population. This will be sustained by a possible pairing of the annual STI prevalence survey with the annual HIV sero-prevalence survey.
    d. Determining the response of the private sector in the management of STIs through both private physicians and private laboratories.
5. Improve surveillance of STIs by establishing sentinel site surveillance of the most prevalent STIs at one main referral STI clinic in each region. This will enable the Comprehensive Health Center to become the main and final referral point for STIs in Jamaica**.**
6. Establish Jamaica as a WHO STI sentinel site in Latin America so that STI prevalence data for the region may be obtained.

3.26 National Integrated Strategic Plan (NISP)

3.26.1 Process Evaluation of the NISP (2014-2019)

Process evaluation of the NISP 2014-2019 was conducted in 2017 in preparation for developing a responsive strategic plan for the upcoming period 2020-2025. As reported in the Jamaica NISP Evaluation Report (2018), in 2013, pursuant to a decision taken by Jamaica's Cabinet, elements of the National HIV/STI Programme were integrated into the National Family Planning Board (NFPB) thus designating the NFPB as the national authority for sexual and reproductive health. The National Family Planning Board, empowered by the National Family Planning Act (1970), is the Government agency responsible for preparing, implementing, coordinating, and promoting sexual and reproductive health services in Jamaica.

One telling finding from the report posited that matters of Sexual and Reproductive Health (SRH) are not reflective of integration, but are rather heavily HIV indicator concentrated. After wide consultation on this and other findings, the drafting of the new NISP has begun, which will aim to include and harmonise SRH-related indicators that are measurable and pertinent, and captured in a representative manner that is reflective of Jamaica's vision for the integration of services. These service areas include Family Planning, HIV/AIDS/STIs, Maternal and Child Health, Gender-Based Violence, Population and Development, *inter alia.*

3.26.2 The New NISP 2020-2025

A new Jamaica National Integrated Plan for Sexual and Reproductive Health (NISP) 2020-2025 is being developed (via consultations) in order to serve the continuation of the expiring strategic plan for the period 2014 – 2019. Its guiding principles will be reflective of an integrated sexual and reproductive health approach as a social logic, social determinant, and health regime.

The NISP seeks to create a pathway through targets, strategies and envisioned outcomes that will likely enable the provision of a comprehensive package of services to meet unmet family planning needs, and, at the same time, significantly reduce risk of HIV/STI transmission, and gender-based violence, and improve maternal and child health. This Plan depicts an opportunity to enable evidence-based programming and creatively adapted to the socio-cultural realities of Jamaica with the strategic objective of significantly contributing to meeting the 2030 target: End AIDS as a public health threat.

The proposed priority actions for 2020-2025, as per recommendations from the various consultations and the Process Evaluation are *inter alia*, as follows:

- Enable SRH integrated service (including family planning, HIV and population and development) in order to achieve reach and distinctive competence in the nation's interest.
- Use the NISP 2020-2025 as an evidence-based tool that will undoubtedly continue to inform policy and programme interventions, and at the same time, act as a model for other countries.
- Review the existing strategy aimed at expanding testing opportunities to include point of care testing and self-testing.
- Further develop the capacity of HCW to provide non-discriminatory services to key population, as well as adolescents.
- Sustain and expand current approaches to achieve retention in care & viral suppression through roll out of linkage to care protocol as well as access to social protection measures that address the social determinants of health.
- Promote and actively support schools to provide age-appropriate information - including the related laws governing minorities - and skills to students to help them to make informed choices that will protect them from unintended pregnancies and STI including HIV.

3.27 Strategic Information

In a bold yet globally innovative move, the HIV/STI/TB Unit has adopted a more comprehensive approach to data capture, analysis and use by re-equipping and transforming its Monitoring and Evaluation function into the new Strategic Information Component. According to the 2017 NHP Annual Report, the SI component exceeded the boundaries of monitoring and evaluation to include surveillance, research and health information systems. The implementation was effected during 2017.

Primary responsibilities of the SI Unit include the collection, analyses and dissemination of data that is used to evaluate and expand the efficiency and appropriateness of programmes. This is collectively aimed at prevention of HIV transmission, early detection of new HIV infections and treatment of HIV infected individuals. The NHP relies on the SI component to shape its objectives, inform and improve strategy and programming, and monitor progress through research, analysis and forecasting. Programme Managers, policy-makers and stakeholders rely on quality information to make informed decisions that are in the best interest of the people and groups they serve. The SI component enables the NHP to respond proactively to the epidemic.

3.27.1 Health Information System

Improving the health information system is critical to achieving epidemic control. This was realized through the design of two electronic databases that allow individual patient tracking from outreach testing through treatment to viral suppression. According to the report, replacing the stand-alone systems, which were not linked or accessible from a central location, the two (2) DHIS2 web-based databases, provided for clean de-duplicated data in real time to allow analysis, dissemination and usage of reliable information in decision-making. The 2 databases were officially rolled out in 2017; dubbed the Treatment Services Information System (TSIS) and the Prevention Services Information System (PSIS), respectively.

In 2018, the TSIS was upgraded to more secure, user friendly system with better functionality for client level data capture and use. The upgrade of the system was accompanied by mergers to the National Public Health Laboratory system allowing viral load results to be available at the site level in real time thus eliminating a delay in the return of results through the paper based system. All viral loads are processed centrally at the facility, so this merger improves patient management at all treatment facilities.

Jamaica's efforts toward achieving complete elimination of mother-to-child transmission status must be supported by reliable data. To that effect, a new database, which was designed for the Prevention of Mother-to-Child Transmission programme was implemented in 2017 and upgraded in 2018. This web-based database, which is available at all PMTCT sites, allows data to be quickly captured at the national level. This exciting development allows for immediate resolution of challenges experienced at local PMTCT sites.

3.27.2 Research

The year 2018 saw the completion of the Knowledge, Attitude, Behaviour and Practices Survey, Integrated Biological and Behavioural Surveillance Survey with Population Size Estimation among Men who have sex with Men and Transgender Persons in Jamaica and the STI Surveillance of Female Sex Workers as an addition the PLACE study conducted in 2017. The Annual HIV Sentinel Surveillance Sero-Survey was also conducted.

Data collection for the *Integrated Biological and Behavioural Surveillance Survey with Population Size Estimation among Men who have Sex with Men and Transgender (TG) Persons in Jamaica* began in December 2017. The study was used to estimate the size of the MSM and TG population, HIV prevalence and risk behaviours for these groups.

The *Annual HIV Sentinel Surveillance Sero-survey* was conducted in sentinel sites from three urban parishes and three rural parishes from all four health regions. This survey is

used to determine the prevalence of HIV in the general population and at-risk populations. This survey includes STI clinic attendees and antenatal care clinic attendees.

The *Knowledge Attitude Behaviour and Practice Survey* was conducted over a six months period. The survey tracked the attitude and behaviour of the public to the HIV/AIDS epidemic as well as monitored the impact of current interventions. Data was collected island-wide from a cross-sectional, household-based, survey among randomly selected sample of 2,000 persons aged 15-49 yrs.

Another research focusing on ART outcomes was started in 2018, this will assess the factors contributing to treatment failure, loss to follow-up and mortality. The outcome of these studies will improve programme planning and decision-making and impact the quality of care given to PLHIV in Jamaica.

3.27.3 Monitoring and Evaluation

Monitoring is an ongoing process of data collection and analysis, which allows assessments of the various activities and interventions undertaken by the Programme. It aims to track performance and improve the decision-making process that guides all projects. This function is undertaken through site audits, supportive supervision and data extraction from the electronic HIV prevention and treatment databases. The existing databases allow extraction of reports that reflect prevention outreach activities targeting key populations. Testing data is de-duplicated, a process that is facilitated by the unique identifier code (UIC) that is produced by the database. This allows individual tracking of clients being tested and their movement, if tested positive, through the continuum of care.

The treatment database strengthens monitoring through the reports generated at the national, regional and site levels. The primary reports allow monitoring of:

- PLHIV who are lost to follow-up, so they can be identified in the community setting and returned to care.
- PLHIV who are defaulting so interventions can be done to prevent lost to follow-up.

- PLHIV who are retained in care and their ART status to ensure all clients are initiated in keeping with ‘Test & Start’ initiative.
- PLHIV on ART to ensure suppression.

The Unit conducted a 12 Component M&E Assessment that assessed the current M&E System and provided a roadmap to benchmark progress made and identify gaps and areas in need of system strengthening. The findings of this assessment served as a platform for the development of an *Integrated Monitoring and Evaluation Plan (2019 - 2024)* which will be further updated to be aligned to the National Integrated Strategic Plan.

3.27.4 Jamaica Monitoring and Evaluation Reference Group (J-MERG)

The J-MERG, which is an independent national advisory body of influential partners, policy experts and technocrats in HIV, STI, research and M&E, continues to provide guidance to the HIV response in the generation, dissemination and use of HIV strategic information, and the validation of national reports such as the GAM and NCPI.

The J-MERG comprises four technical working groups; namely: Data Sharing and Data Use; Evaluation; Guidelines for Key Population; and Research Agenda. The latter shared the findings from a research which was embarked upon by the Family Planning Association, which was the lead for this TWG. The research addressed matters of health and family life education in schools (with permission from the Ministry of Education).

3.27.5 Monitoring and Evaluation Project3

Funding was obtained from the Caribbean Community to do work around sexual and reproductive health. The target audience were two-fold: grades 7-9 students, whereby the guidance counsellors and teachers were part of the focus group discussions; and members of the high-risk communities such as sex workers, LGBT and members of the disabled community.

The main findings from this research involving students reported that:

- Some teachers expressed discomfort at teaching topics relating to sex.
- Students were aware of condoms and pills as dual methods, and that the condom was the contraceptive that could prevent HIV and STI.
- Some teachers were not fully aware of matters relating to sexual and reproductive health, including HIV and STI

The key findings from among the high risk groups revealed that the population needs to be more informed about HIV and STIs, particularly on matters relating to window period, signs and symptoms; personal risks; and distinction between HIV and AIDS.

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