National HIV Program, Jamaica
Country Progress Report
To the Secretary General of the United Nations
On the United Nations General Assembly Special Session

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Ministry of Health
Jamaica

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ACRONYMS

AIDS …………………Acquired Immune Deficiency Syndrome
ANC…………………..Antenatal Clinic(s)
ART …………….……Antiretroviral Therapy
ARV ……………..……Antiretroviral
CRIS ……………..……Country Response Information System
SW ……………….…...Sex Workers
GAMET ………………Global HIV/AIDS Monitoring and Evaluation Team
HFLE …………………Health and Family Life Education
HIV …………..………Human Immunodeficiency Virus
JN+ …………………...Jamaican Network of Seropositives
KABP…………………Knowledge, Attitudes, Behaviour, and Practices
M&E ………………..…Monitoring & Evaluation
MEASURE ……….....Monitoring and Evaluation to Assess and Use Results
MERG………………...Monitoring and Evaluation Reference Group
MSM. ……….………..Men who have Sex with Men
MICS…………………Multiple Indicator Cluster Survey
NHP ………….…...…National HIV Programme
NAC…………………..National AIDS Committee
NGO …………….……Non-Government Organisation
OVC ……….………....Orphans and Vulnerable Children
PAHO……………..……. Pan American Health Organisation
PLACE …….…………Priority for Local AIDS Control Efforts
PLWHIV …….….……Persons Living with HIV
PMTCT ……….……...Prevention of Mother to Child Transmission
STI ………..……........Sexually Transmitted Infections

UNAIDS ……………..United Nations Programme and AIDS

UNFPA………………..United Nations Population Fund

UNGASS ....United Nations General Assembly Special Session on HIV/AIDS

UNICEF ……………...United Nations Children's Fund

UNESCO……………. United Nations Educational, Scientific and Cultural rganization

UNDP…………….…...United Nations Development Programme

VCT …………......…....Voluntary Counselling and Testing

I. Status at a glance

The epidemic in Jamaica has features of both a generalized and concentrated epidemic with an HIV prevalence of 1.3% in the general adult population, 9% among sex workers (SW) and an estimated 25% to 30% among men who have sex with men. Sentinel surveillance of Antenatal Clinic (ANC) attendees suggests that there has been no significant change in HIV prevalence among the general adult population over the last decade. However, persistent behavioural, social and cultural factors continue to fuel the epidemic in high risk groups and it may be premature to state that the epidemic has stabilized. High rates of multiple sex partners among men, increased transactional sex, and early age of sexual debut are important ingredients for further spread of HIV. Some of these behaviours are driven by increasing poverty, population dynamics, and well-established gender roles in which men are sexual decision makers. However, there has been a significant decline iin AIDS Deaths and mother-to-child transmission of HIV, over the past two years.

The Jamaica National HIV Program aims to strengthen the current national response to HIV by implementing strategies to achieve universal access to prevention, treatment care and support. These include:

- Development and implementation of a National HIV Policy.
- Development of HIV policies in various sectors including workplaces.
- Sensitization and identification of advocates among high level leadership.
- Scaling up of prevention services including interventions for persons most at risk for HIV infection, targeted community interventions and social marketing.
- Increased access to prevention services for adolescents by development and implementation of a revised Health and Family Life Education (HFLE) curriculum that increases knowledge and skills that support risk reduction.
- Expansion of HIV testing programs to ensure early diagnosis of HIV infection, appropriate timing of treatment and access to positive prevention.
- Scaling up of access to treatment for PLWHIV and ensuring that services are of a high quality.
- Reduction of stigma and discrimination through sensitization and education, use of mass media, and establishment of mechanisms for monitoring reports and redress of cases of discrimination and the meaningful participation of PLWHIV.

These strategies are captured by the 4 priority areas of a new strategic plan (2007 to 2012) which was drafted after stakeholder consultations:

- Prevention
- Treatment care and support
- Enabling environment
- Empowerment and governance

Table 1. Core Indicators for the Implementation of the Declaration of Commitment on HIV/AIDS, Jamaica: January 2006-December 2007 reporting

Indicators	
National Commitment & Action	
Expenditures	
1. Domestic and international AIDS spending by categories and financing sources	
Policy Development and Implementation Status	
2. National Composite Policy Index National Composite Policy Index **Areas covered**: gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation	See Annex 2
National Programmes (blood safety, antiretroviral therapy coverage, prevention of mother-to-child transmission, co-management of TB and HIV treatment, HIV testing, prevention programmes, services for orphans and vulnerable children, and education)	
3. Percentage of donated blood units screened for HIV in a quality assured manner	100%
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	50% (2005 – ARV Program monitoring) 53% (2006 – ARV Program monitoring) 61% (Nov 2007 – ARV program monitoring) -It is estimated that there are 6,000 Jamaicans living with advanced HIV.
5. Percentage of HIV positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	47% (2004 – PMTCT Program monitoring) 65% (2005 – PMTCT Program monitoring) 85% (2006 - PMTCT Program monitoring) 85% (June 2007 – PMTCT Program monitoring)
6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	64% received co-trimoxazole; 72% received ART (2006 National TB program records) -There were 25 HIV positive incident TB cases in 2006, and it appears that all who met criteria for ARV received such treatment.
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	Men: 12.2% Women: 18.3% (2004, National Knowledge, Attitude, Behaviour and Practices (KABP) survey)
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results	43% of SW (2005 second generation surveillance of 450 female sex workers)

9. Percentage of most-at-risk populations reached with HIV prevention programmes	60% of SW (2005 second generation surveillance)
10. Percentage of schools that provided life skills-based HIV education in the last academic year	24% of 1014 primary and secondary schools (2007, Ministry of Education HFLE Program monitoring)
Knowledge and Behaviour	
11. Current school attendance among orphans and among non-orphans aged 10–14*	0.97 Male; 1.01 Female 0.99 urban; 0.99 rural (2005- Multiple Indicator Cluster Survey)
12. ** % of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission **(Target: 90% by 2005; 95% by 2010)**	38.1% of 15-24 y.o; 45.9% of 25-49 y.o (2004 National KABP) Females 46.7%, Males 22.8% (2004 KABP) Women: 59.8% (urban), 57.9% (rural) (2005 MICS)
13. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	26.1% of SW (2005 second generation surveillance)
14. Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15	Men: 47.7% Women: 15.2% (2004 KABP)
15. Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	Men: 48% Women:: 11%(2004 KABP)
16. Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse*	Men: 66.9% Women: 53.8% (2004 KABP)
17. Percentage of female sex workers reporting the use of a condom with their most recent client	84.2% (2005 second generation surveillance)
18. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Data collection underway
19. Female and male median age at first sex	17.2 Females, 15.7 Males (2004 KABP)
20. ** % of young women and men aged 15-24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner	66% Females, 74% Males (2004 KABP)
Impact	
21. **% of young women and men aged 15-24 who are HIV infected **(Target: 25% in most affected countries by 2005; 25% reduction globally by 2010)**	1.1% (2004 sentinel surveillance of ANC clients) 1.5% (2005 sentinel surveillance of ANC clients) 1.3% (2007 sentinel surveillance of ANC clients, preliminary)

22. Percentage of most-at-risk populations who are HIV infected	9% of SW (2005 second generation surveillance) 3.3% of inmates (2006, Surveillance of inmates) 25% – 30% est. (2007, estimated prevalence for MSM – Data collection in progress)
23. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	75% (2000, ARV program monitoring) 87.6% (2007, ARV database) 2007 data collected at 4 of 19 sites, which include sites representative of urban/rural and large/small populations.
**** Millennium Development Goals**	

II. Overview of the AIDS epidemic

It is estimated that, as of 2007, 25,000 persons or approximately 1.3% of the Jamaican adult population is HIV infected and that almost two thirds of HIV infected persons are unaware of their status. Higher HIV prevalence has been recorded in vulnerable groups such as SW (9%), MSM (25 to 30%), and persons with STIs (3.6%), crack/cocaine users (5%), and prison inmates (3.3%) (Table 2). Sentinel surveillance of women attending antenatal clinic indicate that there is no significant change in the prevalence of HIV over the last decade despite prevention efforts.

Table 2. Epidemiological Profile: HIV/AIDS indicators

INDICATORS	JAMAICA
HIV prevalence rate, aged 15-49	1.5% (2005, sentinel surveillance of ANC sites) 1.3% (2007, sentinel surveillance of ANC sites)
HIV prevalence rate among CSW	9.0% (2005, second generation surveillance of SW)
HIV prevalence rate among MSM	25% to 30% (2006 estimate)
HIV prevalence rate among STI clinic attendees	4.6% (2005, sentinel surveillance of STI clinic attendees) 3.6% (2007, sentinel surveillance of STI clinic attendees)
HIV prevalence rate among inmates	3.3% (2006, surveillance of inmates)
Reported AIDS deaths	432 (2006, HIV surveillance system)

At the end of 2006, the cumulative number of persons reported with AIDS in Jamaica was 11,739 and the cumulative number of AIDS deaths was 6,673 (Table 3). Approximately 65% of all reported AIDS cases in Jamaica are in the 20-44 year old age group, and 90% of all reported AIDS cases are individuals between 20 and 60 years old. In 2006 the number of newly reported AIDS cases in young girls in the 15-24 year old age group was two times higher than that of boys of the same age group. However, significantly more men with AIDS are reported in the 35 to 60 year old age group when compared to women in that age group. In 2005, adolescent females in the 10 to 19 year old age group had three-times-higher risk of HIV infection than boys of the same age group. These findings may be related to the high rate of transactional sex, sexual intercourse with HIV-infected older men and forced sex.

Table 3: Summary of AIDS Cases in Jamaica, 1982 to 2006

PERIOD	TOTAL	MALE (%)	FEMALE (%)
Cumulative 1982-2006	11739	6783 (57.8)	4956 (42.2)
Jan - Dec. 2000	903	515 (57.0)	388 (43.0)
Jan - Dec. 2001	939	511 (54.4)	428 (45.6)
Jan - Dec. 2002	989	580 (58.6)	409 (41.4)
Jan –Dec 2003	1070	611 (57.0)	459 (43.0)
Jan – Dec 2004	1112	603 (54.2)	509 (45.8)
Jan – Dec 2005 *	1344	696 (51.8)	648 (48.2)
Jan - Dec 2006 *	1186	659 (55.6)	527 (44.4)

Note: * Beginning in 2005, Advanced HIV (CD4 > 350) cases are included among total AIDS cases

All 14 parishes in Jamaica are affected by the HIV epidemic but the most urbanized parishes have the highest cumulative number of AIDS cases (St. James – 992 AIDS cases per 100,000 persons and Kingston & St. Andrew – 697 cases per 100,000 persons).

Although heterosexual transmission is the main route of transmission of HIV (reported by 90% of persons with HIV), the sexual practice of 40% of reported male AIDS cases in Jamaica is unknown. Among reported male AIDS cases on whom data about sexual practices are available (60% of cases), homosexual or bisexual activity is reported by 14% of men. Among reported AIDS cases on whom risk data are available (73% of cases), the main risk factors fuelling the epidemic are multiple sex partners, history of STDs, crack/cocaine use, and sex with prostitutes (see Table 3). In 2006, about 25% of persons living with AIDS reported 'sex with prostitutes' as one of their risk factors and almost one out of two persons living with AIDS had a history of STI as a risk factor (Table 4).

Table 4: AIDS Cases in Jamaica by risk category (1982 – 2005 cumulative)

RISK	NO. OF PERSONS (%)
Sex with sex worker	2104 (24.5)
Crack, Cocaine Use	715(8.3)
STD History	3966 (46.1)
IV Drug Use	92 (1.1)
Multiple Sexual Partners/Contacts	~ 80%
No known high risk behaviour	~ 20%
Total	8597 reported

Key populations at higher risk that have been identified include:

Adolescents. Behavioural surveys suggest that adolescents are engaging in high risk behaviour. In 2005, a Youth Resiliency survey, a nationally representative cross-sectional survey of 3000 in-school adolescents, 10 to 14 years old, showed that 12% of surveyed adolescents were sexually active and of these, 56% had 2 or more partners (including 18% of respondents who had 6 or more partners). Forty-eight (48%) of male youth reported no condom use at last sex. Although most adolescents agreed to their first sexual encounter, 9% of boys and 24% of girls reported that they were forced to have sex on their first sexual encounter. In a similar study conducted with 1320 participants island-wide, who were representative of the population of 15-19 year old youth (599 males, 721 females), most of the youth (59%) reported ever having sex (Youth Risk and Resiliency Behaviour Survey 2006). Of these young people who had reported ever having sex, 4% stated that their first sexual encounter was unwanted, either forced or they disagreed but did or said anything.

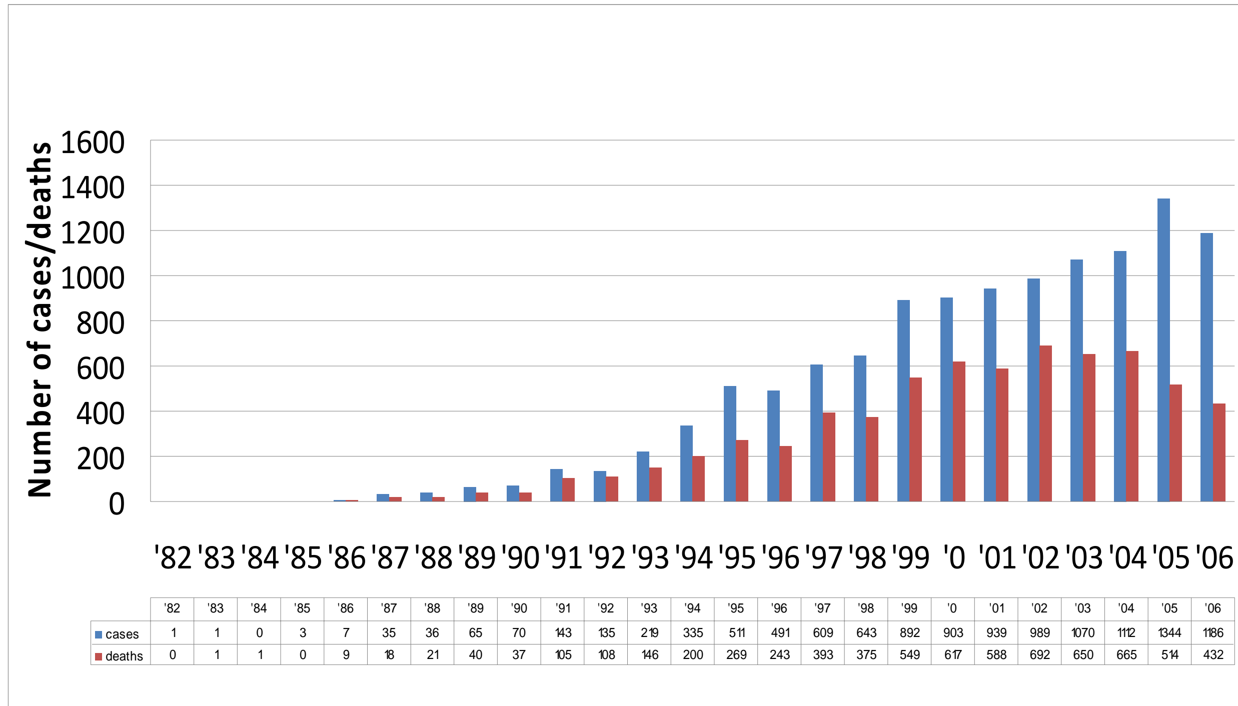
Sex workers. A 2005 survey of four hundred and fifty (450) sex workers showed that condom use with clients (≥ 80%) was significantly higher than condom use with non-paying partners (52%). While knowledge about ways to prevent HIV/AIDS transmission was high, rejection of myths was low among SW, as in the general population. Ninety-seven percent of SW reported having easy access to condoms (accessible within 5 minutes). HIV prevalence was found to be 9% in this population. The sample included primarily street-based SWs, who are more likely to be HIV infected. This was a non-random sample and there may be a selection bias.

MSM. Currently, it is estimated that the MSM population in Jamaica varies from 9,000 to 27,000 and 25 to 30% of MSM are HIV infected. Surveillance data among this population is sparse because of difficulty obtaining adequate samples of MSMs for population studies, and many of those who are HIV infected do not disclose their sexual practices.

Inmates. An estimated 5,000 persons were incarcerated in Jamaica 2005. A recent estimate in one institution found the HIV prevalence among inmates to be 3.3%. Sodomy is illegal in Jamaica so prison authorities are not in a position to consider condom access to inmates though they acknowledge high HIV risks among the inmate population. However, there is an active

education program with voluntary HIV testing and counselling in the main institution and provision of ARV treatment to all inmates with advanced HIV and AIDS.

Figure 1: AIDS cases and deaths in Jamaica, 1982 to 2006



	'82	'83	'84	'85	'86	'87	'88	'89	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'0	'01	'02	'03	'04	'05	'06
cases	1	1	0	3	7	35	36	65	70	143	135	219	335	511	491	609	643	892	903	939	989	1070	1112	1344	1186
deaths	0	1	1	0	9	18	21	40	37	105	108	146	200	269	243	393	375	549	617	588	692	650	665	514	432

Note: * Beginning in 2005, Advanced HIV (CD4 > 350) cases are included among total AIDS cases

In 2006, epidemiological data suggest that the survival of PLWHA has increased as AIDS deaths decreased from 665 in 2004 to 432 in 2006 (Figure 1). Similarly, paediatric AIDS deaths went from 34 deaths in 2004 to 13 deaths in 2006 (Figure 1). This is attributed to the introduction of public access to ARV treatment, improved laboratory capacity to conduct investigations such as CD4 counts, viral load and PCRs, and a general improved quality of care. The most recent epidemiological data show a continuation of this trend, with 196 AIDS deaths from Jan to June 2006 compared to 305 AIDS deaths from Jan to June 2005, a reduction of 36% and a further 12% reduction was realised in the similar period of 2007 with only 175 deaths reported. The implementation of pMTCT in 2004, including routine opt-out testing of antenatal clinic attendees, has resulted in the testing of at least 90% of pregnant women presenting to antenatal clinics and more than 80%of HIV infected pregnant women receiving ARVs to prevent mother-to-child transmission. This has resulted in significant reduction in the percent of HIV infected infants born to HIV infected mothers (estimated to be 8 to 10%).

III. National response to the AIDS epidemic

National Commitment

The end of 2006 marked the culmination of the last strategic plan and the drafting of a new strategic plan with new priorities for Jamaica. A participatory approach was used, which included a series of consultations with civil society, three special workshops on youth, gender and policy, and finally a gathering of more than 100 representatives from various stakeholder groups in December 2006 to shape the way forward. The vision guiding the National Strategic Plan 2007 – 2011 is the same as that articulated in the National HIV/AIDS Policy:

To protect the rights of all Jamaicans including those infected with and affected by HIV/AIDS, and to create an enabling environment free of stigma and discrimination and providing access to: prevention knowledge and skills; treatment care and support; and other services.

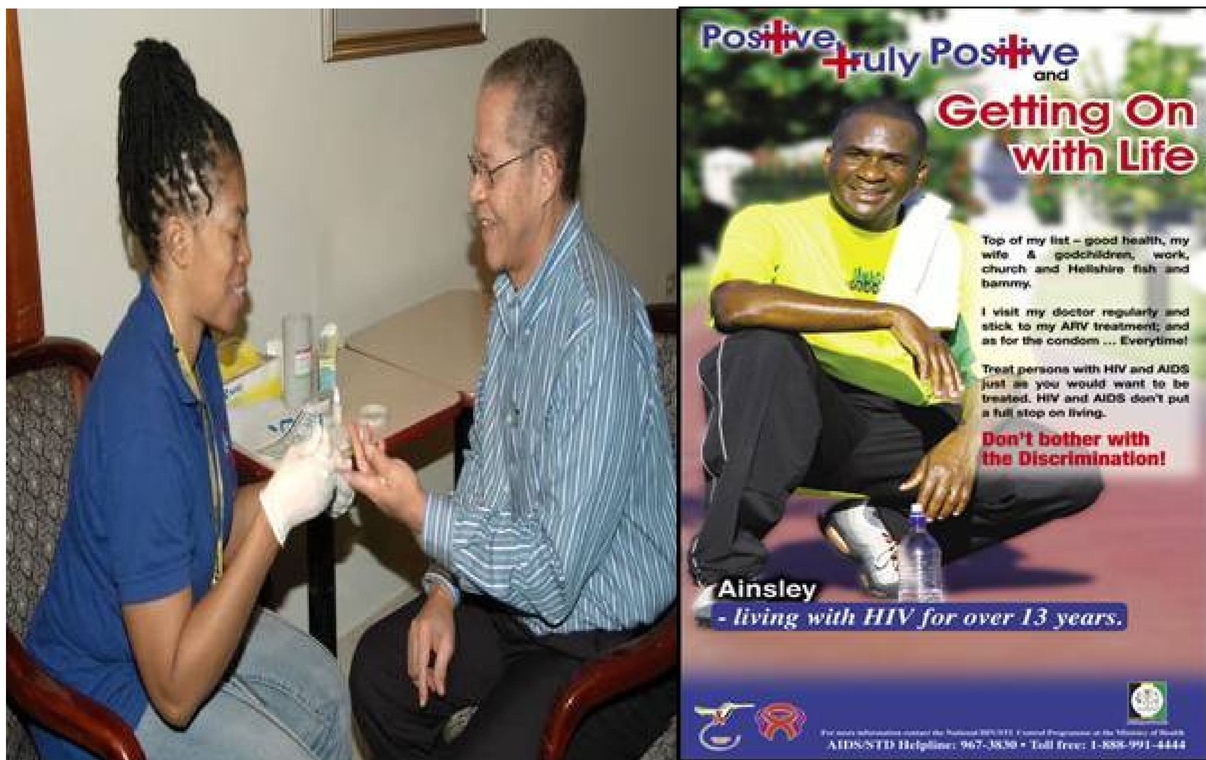
The new priority areas emerging are:

- **Prevention:** This addresses how underlying factors influence risk-taking or appropriate behaviour, what strategies are effective in changing or sustaining behaviour, and the best way to replicate successful strategies.
- **Treatment Care and Support:** This describes the continued development and implementation of an extensive system of care that includes screening and diagnostic services, voluntary counselling and testing, psychological and social support, provision of specialized clinical care and improved access to antiretroviral medications.
- **Enabling Environment and Human Rights:** An enabling environment is one in which all Jamaicans regardless of real or perceived HIV status can be facilitated by policies, programmes and supportive legislation to reduce their risk of infection or re-infection and to access needed treatment care and support.
- **Empowerment and Governance:** Commitment from high-level leaders including politicians and those of the business sector is needed to integrate HIV and AIDS prevention and control strategies into existing human and social development programmes.

The commitment of the government of Jamaica to fight the HIV epidemic is demonstrated by endorsement of these priorities, commitment of resources for the implementation of activities, and participation in HIV research. Important milestones from 2005 to 2007 include:

- Approval of the National HIV/AIDS Policy by parliament in 2005
- The development and implementation of sector and workplace policies by all government ministries by the end of 2006

- Advocacy and public education among high-level leaders, garnering commitment of high level leadership (political and private sector). This includes policy makers, CEOs, lawyers, among others. (See inset of Prime Minister, Honourable O. Bruce Golding participating in VCT on World AIDS Day, 2007).
- The creation of a national advisory group for capturing reports on stigma and discrimination led by the Secretariat of the Jamaican Network of Seropositives in January 2007.
- Participation in HIV vaccine research: Enrolment of volunteers in phase Π and phase Πb HIV vaccine clinical trials began in August 2006. Thirty five persons have been enrolled in 2 different trials..
- Mass Media Campaigns to reduce stigma of people living with HIV and AIDS**:** The "Getting on with Life campaign" was launched on September 15, 2006 (see inset).
- Development of (draft) Strategic Plan on HIV and AIDS for the Ministry of Education in 2007.



Funding and Support

The National HIV response continues to expand involving numerous partners such as the private sector, regional health authorities, line ministries, and more than 20 NGOs. The assessment of national goals and objectives resulted in the development of a National Strategic Plan (NSP) spanning a 5-year period. The current NSP was recently costed by a World Bank consultant contracted by UNAIDS and is estimated to cost US$207.4M for implementation, for the period

2008-2012. The domestic and external sources available from GOJ, World Bank, USAID, UNICEF, Global fund and Private Sector to support this need are estimated to be US$49.5M.

Domestic Sources: The National HIV Programme currently receives counterpart funding from the following domestic sources:

- Government of Jamaica – the government directly contributes to the costs of hospitalizations opportunistic infection drugs, Human resource and infrastructure costs. This will amount to approximately US29.8M
- The International Bank for Reconstruction and Development (lBRD) - the government has undertaken a World Bank loan specifically for the HIV programme. This amounted to US$10.6M for the period 2002-2007.

External Sources: The National HIV Program has also been the recipient of funding from several external sources.

- USAID has been committed to the programme from its inception and contributes a grant of US$1.0M per annum.
- UNICEF covers aspects of Prevention of Mother to Child Transmission, and vulnerable children who are orphaned by HIV and AIDS. UNICEF plays a significant role particularly in supporting the PMTCT programme and contribute approximately US$250,000 per year and this is expected to be increased in the coming years as more funds become available to the organization.
- The current Global Fund Grant approved in round three covers the period June 2004-2009. It provides for US$23 M over the period.

Table 5: Actual and planned financial contributions to national response 2005 – 2007 (Fiscal year April 1 – March 31)

	Actual 2005	Actual 2006	Planned 2007
Domestic Sources			
Loans and debt relief (World Bank)	1,923,077	2,104,615	1,978,783
National funding resources	4,236,923	4,726,154	7,236,601
External Source			
Global Fund	4,491,534	2,992,500	5,239,500
USAID	654,592	538,237	294,390
Total	11,306,126	10,361,506	14,749,274

Table 6: Comparative Summary of Component Expenditure 2005/2006

	Calendar Year 2005		Calendar year 2006	
Components	**Budget ('000 JA$)**	**Actual ('000 JA$)**	**Budget ('000 JA$)**	**Actual ('000 JA$)**
Treatment, Care & Support	225.011	195.180	409.775	111.286
HIV Prevention	132.902	113.308	111.782	105.964
Capacity Building	28.257	24.187	42.344	71.336
Policy & Advocacy	33.540	37.200	34.665	22.215
Monitoring & Evaluation	9.619	2.085	7.517	3.466
Administration	68.761	77.158	78.346	58.135
HADDS	2.802	10.149	0.975	6.232
RHA	9.500	23.993	24.655	42.059
Line Ministries	3.624	2.392	7.569	9.847
Total	**514.016**	**485.652**	**717.628**	**430.540**

Average exchange rate over this period $68JD = $1USD

In 2006, funds were expended mainly for the following interventions: mass media and outdoor advertising campaigns, procurement of condoms, a special intervention - Priorities for Local AIDS Control Efforts (PLACE), Targeted Community Interventions, special activities for Safer Sex Week and World AIDS Day, procurement of ARV drugs, procurement of rapid test kits, infant formula and STI and OI Drugs, Reagents for PCR test and Viral Load test, medical equipment and supplies, waste management supplies, civil works for treatment sites, monitoring and evaluation activities, Computer hardware including antivirus software and computer software to support the Laboratory Information System and M & E.

Prevention, Knowledge and Behaviour Change

Surveillance data indicate that the HIV epidemic in Jamaica is driven by a combination of socio-cultural, behavioural and economic factors. The most recent national Knowledge, Attitudes, Behaviour and Practices (KABP) survey, conducted in 2004, revealed a persistence of risky behaviours such as multiple partners (50% men) and participation in transactional sex (20% of men and women). Risky behaviour is also evident among adolescents, as the median age of first sex declined to 15.7 (males) and 17.2 (females) in 2004. A 2005 survey of in-school adolescents (10 to 15 years old) reported that 12% of those surveyed admitted to being sexually active, and

among the sexually active youth, 56% had 2 or more partners, and 48% reported no condom use at last sex. These behaviours may be driven by myths concerning HIV and lack of personalization of risk as only 36% of young men and 40% of young women were able to correctly identify ways of preventing HIV and reject major misconceptions about HIV. Similarly, a 2005 survey of sex workers indicated that 32% of HIV negative SW and 18% of HIV positive SW were able to correctly identify ways to prevent HIV infection.

However, the Multiple Indicators Cluster survey (MICS) conducted in 2005 suggests that women are increasingly aware of myths pertaining to HIV as most women 15 to 49 years old surveyed in 2005 knew that HIV cannot be transmitted by mosquitoes and that a healthy looking person can have HIV (Table 6). The composite indicator of knowledge of HIV prevention and rejection of myths also showed improvement in the 2005 MICS as approximately 60% of women aged 15 to 49 years old were able to identify 2 prevention methods and reject 3 misconceptions in 2005 compared to 47% in 2004.A national KABP will be conducted in early 2008 and will provide behavioural data for men and women 15 to 49 years old. MICS was technically and financially supported by the UN in Jamaica, i.e. UNICEF, UNAIDS, UNESCO and UNDP and technically supported by a Steering Committee comprising of the Cabinet Office, Early Childhood Commission, Planning Institute of Jamaica, Sir Arthur Lewis Institute for Social and Economic Science, Caribbean Child Development Centre of the University of the West Indies, UNAIDS, UNFPA, PAHO, Child Development Agency and the Ministry of Health.

Table 7: Percentage of women aged 15-49 years who correctly identify misconceptions about HIV/AIDS, Jamaica, 2005

		Percent who know that:			Reject two most common misconceptions and know a healthy-looking person can be infected
		HIV cannot be transmitted by supernatural means	HIV cannot be transmitted by mosquito bites	A healthy looking person can be infected	
TOTAL URBAN	TOTAL URBAN	94.2	83.3	96.7	77.7
Area	KMA*	95.5	85.5	96.4	80.1
	Urban	92.3	80.1	97.1	74.1
	Rural	93.4	78.4	94.0	72.6

*KMA – Kingston and metropolitan St. Andrew

Table 8: Knowledge of preventing HIV transmission and comprehensive knowledge, Jamaica, 2005

		Percentage who know transmission can be prevented by:			Knows all three ways	Have comprehensive knowledge (identify 2 prevention methods and 3 misconceptions) *
		Having only one faithful uninfected sex partner	Using a condom every time	Abstaining from sex		
TOTAL URBAN	TOTAL URBAN	81.6	90.2	88.9	68.8	59.8
Area	KMA	79.0	88.7	86.8	64.6	58.8
	Urban	85.3	92.4	92.0	74.8	61.1
	Rural	86.0	86.8	84.6	68.0	57.9

Socio-cultural and economic factors also contribute to the vulnerability of many persons and result in persistent risky behaviours. High levels of unemployment, persistent poverty, and a growing commercial sex industry coupled with gender inequality have resulted in early sexual debut, age-mixing (sexual relationships between adolescent girls and older men) and increasing transactional sex. Although 50% of men reports having multiple sex partners, men are often the sexual decision makers and condom use negotiations are difficult for women.

The national HIV program has undertaken some key strategies in 2006 and 2007 to establish a comprehensive programme of prevention services, which achieves full coverage and aims to empower all sexually active men and women. These include:

- **Targeted Community Interventions.** The regional NHP teams worked to mobilize local communities with high HIV transmission rates by engaging them in the design, implementation and evaluation of community-specific interventions.
- **Targeted Interventions among key populations at high risk.** Activities with key populations at high risk such as MSM, CSW, and prison inmates include risk reduction counselling, screening for STIs, rapid testing for HIV, referral for treatment, and distribution of condoms.
- **Media campaigns: An abstinence campaign was developed and tested.** The first run of an Adherence campaign concluded in June 2006. The campaign ran for three months on the two national television stations as well as four radio stations. Other campaigns being developed include the voluntary blood donor program, VCT expansion of testing and Friends helpline.
- **Partnering with key line ministries** including the ministry of education, ministry of national security, ministry of labour, and ministry of tourism. This ensures a multisectoral response and facilitates HIV prevention activities in the various sectors. These partnerships have been productive and have led to increased ownership of the response by various ministries. For example, the Tourism Sector

has developed a Workplace HIV/AIDS Policy that was approved by Cabinet in March 2007. An official launch of the Policy took place on June 6, 2007. To date, 200 copies of the Policy have been printed and 500 placed in CDs for distribution to the tourism entities. Additional copies will be printed at a later date.

- **Partnering with the private sector and NGOs** included meaningful alliances with the business sector through the Business Council and Jamaica Employers Federation, facilitating workplace policies and programs. The partnerships with NGOs were instrumental to establishing links to key groups at high risk.
- **Social Marketing, Materials and Public Relations** including development and distribution of numerous materials to raise awareness about HIV and promote safer sexual behaviour including low literacy STI brochures and risk cards.
- **PLACE (Priority for Local AIDS Control Effort) randomized control trial:** PLACE began as a mapping tool to accurately identify and characterize the locations where people meet new sexual partners. PLACE was rolled out to other areas in Jamaica, i.e. May Pen and St. James. In addition, the National AIDS Programme, with assistance from the MEASURE project, completed a randomized control trial comparing various interventions in locations identified through PLACE.
- **Establishment of over 100 new non-traditional condom outlets** e.g. taxi drivers, influential persons at night clubs. Recent surveys show ready access to condoms, however, MSM and adolescents may be reluctant to seek condom
- **Development of a National Medical Waste Management Policy** and a strategy to manage medical waste by establishing facilities in each of the four health regions. Infectious waste disposal supplies have been procured.
- **Expansion of HIV testing** led to a highly successful programme that has been rolled out islandwide, with 2,251 VCT counsellors trained between 2004 and 2006 as well as 63 trainers, 11 advanced trainers and 6 master trainers. This resulted in significant scale up of HIV testing. Provider initiated testing for all hospital admissions was also introduced in 2007.

Treatment, Care and Support

It is estimated that of the 25,000 PLWHIV, two-thirds of infected persons are unaware of their status, and approximately 6,000 persons have advanced HIV and are in need of treatment. The public access to treatment program was established in September 2004 and in 2006 treatment guidelines were revised to include new options for second line therapy. Based on programme monitoring, 3,637 adults and children with advanced HIV (60% of persons with advanced HIV) were on treatment at the end of October 2007. The impact of the treatment program is reflected in surveillance data, which shows a decrease in the number of AIDS deaths from 665 in 2004 to 432 in 2006.

Increased HIV testing, especially in key groups at high risk for HIV infection, has been a programmatic priority for the last 2 to 3 years as early diagnosis of HIV infection is recognized as a means for access to treatment and positive prevention. Expansion of the HIV testing

program has been achieved by involvement of private laboratories (HIV testing without referral by health care provider), provider initiated testing, reduced cost of HIV testing, and opt-out testing for persons most at risk including pregnant women, STI clinic attendees and hospital admissions. Activities to promote HIV testing and knowing one's status have been widespread and were reinforced in 2006 on World AIDS Day under the theme "**Stop AIDS. Keep the Promise-Get Tested".** Consequently, the number of HIV tests has increased from 80,000 in 2003 to over 130,000 in 2006 and the percent of pregnant women tested for HIV has increased from 39% in 2003 to 95% in 2006.

A well established pMTCT program has resulted in provision of ARVs for 85% of pregnant women delivering in the public sector and 93% of HIV exposed infants in 2006. Guidelines for delivery of care to HIV infected mothers were revised in 2006 and now include HAART for HIV infected women. However, nearly 20% of women and 10% of HIV exposed infants continue to escape the net of the current pMTCT program due to late presentation to antenatal care (first point of contact when in labour) and failure to disclose HIV status when presenting to the health system. HIV infected mothers sometimes refuse replacement feeds because of a fear that failure to breastfeed may be admission of one's status and HIV exposed infants are sometimes lost to follow up. Education about the availability of services for pMTCT and introduction of rapid testing on the labour wards are 2 strategies used to close this gap. In addition, strengthening of the roles of members of the multidisciplinary team involved in the care of PLWHIV (social workers, psychologists, nutritionists and adherence counsellors) continue to be programme priorities.

Other activities undertaken to strengthen the treatment, care and support of PLWHIV from 2006 to 2007 include:

- **Establishment of an additional treatment site** (a total of 19 sites islandwide).
- **Revision of treatment and pMTCT guidelines.** Manuals were disseminated and training conducted for relevant health care workers on the revised guidelines, which are in keeping with international standards.
- **Implementation of provider initiated testing** for HIV as a routine strategy to increase access to HIV testing. Other strategies continued in 2006 include opt-out testing of pregnant women, hospital admissions, and STI clinic attendees; use of rapid testing on the labour wards; and decentralization of confirmatory HIV testing.
- **Strengthening of the adherence program** by revision of adherence guidelines and continued support for adherence counsellors islandwide.
- **Improved laboratory capacity** to identify indicators of progression of infection/immune impairment (e.g. CD4 count and viral load).
- **Involvement of civil society** in the Care and Support of PLWHIV, increasing access to treatment and a better quality of life.
- **Introduction of an electronic patient register** at all treatment sites to facilitate monitoring persons receiving ARVs.

Impact Alleviation

Stakeholders in the national response to HIV in Jamaica play a critical role in impact alleviation. Initiatives by the government of Jamaica such as free health care for persons under 18 years of age, access to primary and secondary education at minimal costs, and social assistance programs have benefited vulnerable populations including PLWHIV. In addition, partners such as the National AIDS Committee have provided financial and legal assistance to PLWHIV; back to school assistance for children living with or affected by HIV and AIDS; and implemented friends and family forums to teach family members and friends how to interact with and care for PLWHIV. These activities are supported by implementation of appropriate policies and advocacy for PLWHIV by high level leadership.

Data from a 2005 Multiple Indicator Cluster Survey (MICS) reflect the impact of some of these initiatives on outcomes such as school attendance among orphans and vulnerable children (OVCs). The MICS consists of several modules under 3 standard questionnaires (household, woman and child) and uses stratified random sampling to interview occupants of 6,128 dwellings across Jamaica. The 2005 MICS provided data for the Millennium Development Goal (MDG) indicators for OVCs:

- Ratio of current school attendance among orphans to that among non-orphans, aged 10-14

The findings of the MICS pertaining to current school attendance among OVCs are summarized in Table 8.

Table 9: School attendance among OVCs in Jamaica, MICS 2005.

		OVC vs. non-OVC school attendance ratio
Sex	Male	.97
	Female	1.01

The MICS has some limitations. Firstly, it is a household survey and does not include OVCs in institutions and on the street. Secondly, the survey failed to recognize the access of OVCs to health services, free primary education and other social support services that are heavily subsidized by government as “free basic external support”. This is reinforced by the finding that while 13 to 15% of OVCs were reported as having any free basic external support, school attendance among OVCs was not significantly different from school attendance among non-OVCs (Table 8). In fact, school attendance among orphans and children made vulnerable due to AIDS was 96% among boys and 100% among girls. Essentially, the finding regarding the percent of OVCs whose household received any support does not reflect the services provided by the government of Jamaica or correspond with important outcomes, such as OVC school attendance. It is important to note that as of 2007, recent changes in government policies also guarantee free access to health care in all public sector health institutions and free access to primary and secondary education for all minors (0 -18 years old).

Trends in policy/strategy development and implementation

An analysis of all data and information collated through the NCPI Survey highlights three (3) significant trends relating to Strategic Planning, Human rights and Civil Society Participation.

Strategic Planning: Respondents commended the work being undertaken in the area of multi-sectoral strategic planning and programme impact evaluation. Indicating good, steady and consistent progress made from 2005 to 2007

Human Rights: There is consistency and stability in 2005 and 2007 responses in relation to policy and Programme planning and implementation. There is agreement on the availability of good and effective Policies; existence of multi-prong programming; and the accessibility of services.
There is variation between the 2005 and 2007 Data relating to respect, protection and fulfilment of HIV-related Human Rights (from ‘yes’ in 2005 to ‘no’ in 2007). The shift from affirmative

responses in 2005 on the issue of existence of HIV-related laws and regulations, or laws infringing on protection; to negative responses in 2007 seem to point to Respondents being more aware and knowledgeable and therefore better able to comment on matters of HIV-related Human Rights.

Civil Society Participation: Civil Society involvement, participation and access to services were assessed to be the weakest area. There was a significant difference in the scoring. The score in 2005 was 70 – 80% higher than 2007 with a significant difference on questions relating to Civil Society engagement of political leadership, involvement in planning and accessibility to resources. The decrease in the score given to Civil Society engagement of political leadership from 8 in 2005 to 2 in 2007 may be attributed to a weakened Civil Society generally and not necessarily correlated to HIV; an absence of initiative on the part of Civil Society; and/or lack of adequate and consistent mechanisms to guarantee Civil Society participation and involvement.

In conclusion, the Data clearly demonstrate that Jamaica has made great progress in scaling up HIV response through developing its multi-sectoral National Strategic Plan; consolidating Monitoring and Evaluation component of the Programme and scaling up Prevention, Treatment, Care and Support Programmes and service delivery. However, data also reveal that greater effort to guarantee respect and protection of HIV-related Human Rights; and galvanizing involvement of Civil Society requires strengthening.

IV. Best practices

Priority for Local Aids Control Effort (PLACE)

The Jamaica NHP hosted persons from several Caribbean countries who participated in a PLACE study tour. The PLACE evaluation was implemented in 4 regions in Jamaica with the assistance of the MEASURE group (University of North Carolina). It was used as a mapping tool to accurately identify and characterize the locations where people meet new sexual partners. The methodology consisted of several stages including interviews of key informants to identify meeting sites followed by interviews of persons socializing at the sites to assess sexual behaviour of that population. The results from PLACE have been used in planning and implementation of targeted interventions. In addition, the sites identified in PLACE were used as the population for a randomized controlled trial comparing high intensity prevention interventions (training of influentials (i.e. peer with significant influence among key populations at high risk), periodic HIV testing, etc) to less intense interventions.

Important lessons have been learnt from the research phase and from the randomised control trial and will be applied to interventions. Of particular importance are lessons relating to structured monitoring and evaluation of the quality of the intervention as well as approaches to initiating interactions in the outreach settings, that is, socializing sites, club bars, sex work sites and communities.

PMTCT program

Elements of the pMTCT programme that make it a best practice are:

- Introduction of HIV rapid testing and decentralization of confirmatory HIV test (4 regional labs). This resulted in a quicker turn around time for receiving HIV test results.
- Opt-out testing for all pregnant women presenting to the antenatal clinic increased coverage to >90% pregnant women attending public antenatal clinics.
- Widespread training of public health nurses and physicians involved in antenatal care of women on the guidelines for pMTCT.
- Integration of HIV programmes into existing maternal and child health care programmes rather than establishing separate entities has ensured sustainability of the programme.

These factors have resulted in rapid scaling up of the pMTCT program so that pMTCT services are available at all antenatal clinics.

Workplace Education Programmes

Several examples of best practices, defined as initiatives that contribute to the workplace response to HIV and can be replicated in other settings, are seen in the Workplace Education

Programme initiated by the ILO. The ILO identified the following as Best Practice Organisations:

1. Carimed
2. National Association of Hairdressers and Cosmetologists
3. City Of Kingston Credit Union
4. Sugar Company of Jamaica
5. The Ministry of Labour & Social Security

The achievements of the Workplace Programme in the Ministry of Labour and Social Security are illustrative of the accomplishments in this sector. Some elements that make this programme a best practice are:

- Strong support at the ministerial level and at the highest technical levels.
- Drafting of a National Workplace Policy on HIV/AIDS in consultation with the Policy and Advocacy component of the NHP, the Jamaica Confederation of Trade Union and the Jamaica Employers Federation.
- Approval of the Policy at the Human Resource Sub Committee of Cabinet in March 2007
- Sensitization and training of over 75% of ministry staff in VCT and the Care and Counselling Workshops, and as PEER facilitators.
- Appointment of a HIV/AIDS Steering Committee whose mandate include developing the ministry's policy document.

Policy Development

The accomplishments of the Tourism Sector are also notable, and embody elements of a best practice. The tourism sector has developed a Workplace HIV/AIDS Policy that was approved by Cabinet in March 2007. An official launch of the Policy took place on June 6, 2007. To date, 200 copies of the Policy have been printed and 500 placed in CDs for distribution to the tourism entities. Additional copies will be printed at a later date.

V. Major challenges and remedial actions

Despite progress in most areas, many of the challenges that existed in 2005 have persisted.

1. **Data capturing:** Many new data collection tools have been implemented since 2005 including line ministry reporting forms, reporting forms for behaviour change teams, an electronic patient register for HIV treatment sites and regional reporting forms (captures pMTCT and HIV testing data). The expanded M&E unit also tracks the timeliness of reports and have implemented measures to ensure data quality. These issues have been reinforced at M&E workshops conducted at a national level and in the South East region of the island. Databases are also at varying stages of implementation including a web-based HIV/AIDS tracking system. These activities have facilitated data dissemination at meetings of the Monitoring & Evaluation Reference Group (MERG), national meetings, various stakeholder meetings, and on the NHP's website.

   Major challenges for the current M&E system include the timeliness, completeness and accuracy of information. In some cases, partners are unwilling to use new data collection tools including databases because of the additional effort required to implement new tools and conflicting reporting requirements of donors. Therefore a major priority in the upcoming year is continued training on 3 major issues:
   - The national HIV M&E plan
   - Basic M&E concepts
   - Data utilization and implementation of data collection tools.

   Data capture will continue to be strengthened by working closely with stakeholders to ensure that data collection tools are fully implemented (including databases). In addition, the continued development of the M&E information system will allow automation and efficient processing of the data gathered by the M&E unit.

2. **Access to key populations at high risk:** Some strategies that have contributed to a reduction in stigma and discrimination since 2005 are sensitization of persons in various sectors, a successful mass media campaign against stigmatization of PLWHIV, development of HIV policies in various sectors including all ministries of government and targeted large enterprises, and advocacy among high level leadership. However, sodomy continues to be illegal and persistent fears of being subject to discrimination continue to hamper the implementation of services for some persons at risk.

   The following strategies are detailed in the new strategic plan to promote an enabling environment for PLWHIV:

   - Maintenance of a Multisectoral Reporting and Redress Advisory Group to monitor the reporting of cases of HIV-related discrimination and redress
   - Continued development and implementation of a discrimination reporting and redress system
   - Anti-stigma campaigns
   - Interacting with communities to reduce stigma and discrimination

- Development of a workplace policy for health
- Focus on appropriate services for adolescents
- Full implementation of the revised HFLE curriculum
- Meaningful involvement of PLWHIVs
- Legal Assistance for PLWHIV

3. **Need to expand prevention programs.** The rapid scaling up of prevention programs was a national priority in 2006 and resulted in an expansion of the HIV testing program including outreach testing, mapping of high risk populations, increased targeted community interventions, increased capacity to conduct prevention activities, including training of coordinators, peers. However, the targeted 10 fold increase in prevention activities has not been realized and further expansion of the prevention program will continue to be a priority.

The new strategic plan describes programmatic priorities in order to achieve universal access to prevention services. These include:

- Building Capacity for HIV prevention in all sectors
- Strengthening existing workplace and healthy lifestyle policies
- Comprehensive HIV and AIDS response in the Education sector
- Continued mass media Campaigns, IEC Materials
- Expanded VCT
- Mapping of sites for intervention through PLACE
- Implementation of age appropriate interventions including safe spaces
- Monitoring of quality of prevention services
- Research targeting gender issues and high risk groups
- Implementation of strategies to address positive prevention
- Identification and dissemination of best practices

4. Sustainability of the national response to HIV.

The major sources of funding for the NHP are the government of Jamaica, the Global Fund grant, the World Bank, and USAID. The current World Bank project closes in December 2007 and consequently, the national HIV program is faced with funding gaps as it attempts to scale up activities in order to achieve universal access. Continuity of established systems and interventions are threatened as uncertainty looms over project staff and activities.

These challenges were anticipated and several initiatives have been undertaken to ensure sustainability of the national response. These include:

- Costing of the new national strategic plan
- Identification and documentation of the human resource needs for sustainability of the national response.
- Negotiation with the ministry of health and other relevant ministries for absorption of essential posts.
- Negotiation with the World Bank for additional funds.

While the outcomes of many of these initiatives are pending, Jamaica has been approved for $44M by the Global Fund under its Round 7 funding and has been invited to submit a proposal under its Rolling Continuation Channel which is designed to reward strongly performing Grants with up to six years of additional funding. Additionally, Jamaica is in the process of designing a follow-on World Bank Project. Nonetheless, a gap remains available funding and the cost of the National Strategic Plan (2007 -2012).

VI. Support from the country's development partners

The developmental partners have participated in the drafting of the new strategic plan and have played an important part in the national response to HIV. Provision of financial and technical assistance has facilitated implementation of some activities and the developmental partners continue to play a role in monitoring the local response to HIV. However, despite development of one strategic plan, conflicting priorities sometimes result in the diversion of resources from agreed programmatic priorities to priorities of developmental partners as each organization attempts to accomplish their mandate. Such conflicting priorities cut across all components, from monitoring and evaluation to prevention. In addition, the various reporting requirements of each partner prove to be a strain for some stakeholders, which already have limited human resources. This detracts from implementation of activities.

The development partners may assist with achievement of UNGASS targets by:

1. Strengthening relationships and communication with key stakeholders in the national response.
2. Establishing selves as ambassadors and facilitators of the one national strategic plan rather than presenting obstacles.
3. Continued financial and technical assistance when needed.
4. Harmonization of procurement and reporting requirements.

VII. Monitoring and evaluation environment

The M&E system of the Jamaica NHP has 3 specific objectives:

- To track the implementation of the National HIV/ STI Programme activities and establish whether the programme objectives have been achieved;
- To increase the understanding of trends in HIV prevalence and explain the changes over time to allow for appropriate response to the epidemic;
- To strengthen the capacity of the Jamaica National HIV/ STI Programme, regions, parishes and NGOs and civil society organizations to collect and use HIV/AIDS data.

The M&E system is detailed in an M&E framework and plan which explains how the programme will measure its achievements and provide for accountability to the stakeholder and donor communities by tracking 30 core indicators. Figure 2 illustrates the various components of the M&E system and how they are interrelated to provide information for programmes. The information is presented through various publications, regional and national meetings, and reports on a regular basis. Several of these reports are also posted on the NHP's website.

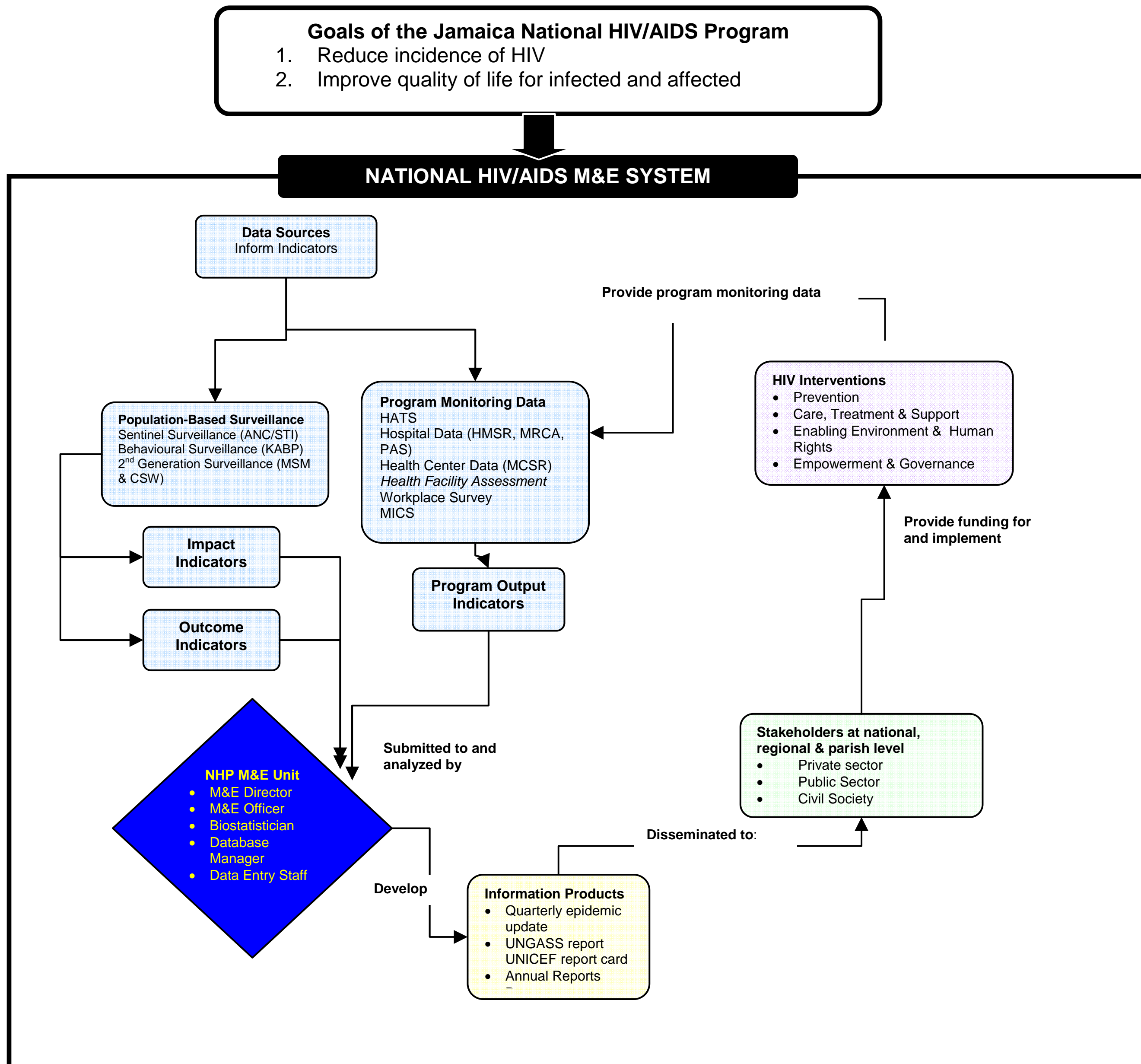


Figure 2: Overview of the Jamaica M&E system

Data sources for various indicators include routine data sources, which collect data on a continuous basis, and non-routine data sources that are collected on a periodic basis, (usually annually or less frequently). Some elements of the M&E system are well established and have provided important output, outcome and impact data to the NHP from as far back as 1986. Examples of routine data sources include:

- **Stakeholder reports:** Many output indicators (e.g. numbers reached by prevention activities, number of CD4 counts done, number of PCR tests done on HIV exposed infants) are collated from monthly stakeholder reports, which are processed by the M&E unit. Stakeholder reports include monthly reports from NGOs, FBOs, line ministries, regional health authorities, regional laboratories and treatment sites.
- **HIV/AIDS Tracking System (HATS):** This is an ongoing HIV surveillance system that is based on confidential case reporting by health care workers in addition to active surveillance

of hospitals, hospices, death registries, among others, by a surveillance officer. Case reports include demographic information, mode of transmission, risk factors, and stage of infection.

- **Sentinel surveillance of antenatal and STI clinic attendees:** This is currently done biennially and provides data on HIV prevalence in youth and STI clients (disaggregated by age, parish and urban/rural categories).
- **The Jamaican Health Information System:** This system consists of a few stand-alone databases which provide information to the M&E system. In particular, the monthly clinical summary report supplies aggregate data on important health indicators from over 300 health centers islandwide.
- **HIV-related Discrimination, Reporting and Redress System:** This system is being developed and is guided by a multisectoral Reporting and Redress Advisory Group, which includes representatives from the NHP, UNAIDS, Human Rights organizations, Ministry of Labour & Social Security, PLWHIV, NHP, among others. Representatives are M&E personnel, PLWHIV, Advocates, Policy Coordinators, and lawyers. A database and data collection tool has been developed. The data collection tool is accessible on the JN+ website.

Although collection of non-routine data is often expensive, and is done on an irregular basis, they often are important for evaluation of existing activities. Some non-routine data sources that are used include:

- **KABP:** a population based survey of 15 to 49 year olds that provide information on sexual behaviour (e.g. condom use at last sex, transactional sex and abstinence), practices and knowledge about HIV. This has been conducted every 3 to 4 years since 1988.
- **Second generation surveillance of SW and MSM:** Limited data is available on many vulnerable populations. However, a survey of SW was conducted in 2005, giving insight into behaviours that fuel the HIV epidemic in this group (e.g. condom use with clients and non-paying partners, availability of condoms, access to prevention services and HIV prevalence). Surveillance of MSM will provide similar information.
- **Workplace survey:** The survey of workplaces involved assessment of provision of workplace policies and programs that address HIV/AIDS. It provided important baseline data and will be conducted every 2 to 3 years**.**
- **Multiple Indicator Cluster Survey (MICS):** The MICS is a household survey conducted by UNICEF with technical and financial support by the UN in Jamaica and a multiagency Steering Committee. This survey provides information on various health and social issues affecting women and children, including HIV/AIDS. The survey is conducted every 4 to 5 years (most recently done in 2005).
- **Special studies:** Research is a priority for the NHP and provides an opportunity for evaluation of interventions and identification of priorities. For example, the PLACE studies in various regions of the island provided a template for targeted interventions and provided information on prevalence of STIs at some sites of socialization.

The M&E system has also made significant progress in working with National partners to integrate Monitoring systems.

- **Threshold 21 (T21)**: The M&E unit has partnered with the Planning Institute of Jamaica to refine the HIV module of the Threshold 21, a dynamic plannng tool. The purpose of the HIV module is to describe the main forces that drive the growth and decline of the HIV epidemic in Jamaica. It is directly linked to the Population Module of the T21, and so tracks how the epidemic impacts various age cohorts, and produces several important indicators to monitor the development of the epidemic. The module also enables users to simulate the effects of a wide range of policies to slow down virus diffusion or limit the effect of HIV on the infected population. This tool is an important step in increasing our ability to make estimates and projections of our key populations at high risk for HIV infection, and importantly, places HIV more centrally as a national planning priority as the T-21 Model is seen as a vital component of Jamaica's 'Vision 2030 National Development Plan'.
- **JamStats:** Using the ChildInfo software developed by UNICEF, the Statistical Institute of Jamaica, in partnership with the Planning Institute of Jamaica and UNICEF Jamaica, created a comprehensive database, JamStats, that allows for tracking key development indicators. The NHP has worked with JamStats to integrate and harmonize HIV-related indicators. This work is critical as JamStats is seen as the main source of indicators which will be used to measure progress in the implementation of the National Development Plan 2030. That HIV-related indicators, aligned to nationally agreed set of HIV indicators, are included in JamStats is an indication of greater efforts to mainstream HIV as a national development priority and is also reflective of the kind of the strategic work in the M&E Unit.

Despite receiving a grade 3 rating ("fully implemented") by a UNAIDS assessment of country surveillance, some gaps persist in the existing M&E system.

1. **Limited capacity of some stakeholders to conducting M&E activities.** This is reflected in reports that are not received in a timely manner and with poor quality data. Hence, on-going training of key personnel from among stakeholder groups is a priority for the 2007 – 2012. Existing collaboration with the MEASURE group (University of North Carolina) will be instrumental in refining existing training curriculum. M&E training will be institutionalized so that new stakeholders are exposed to the required indicators and sensitized about their role in the M&E system. This will enhance the ability of our stakeholder to adequately contribute to the development of HIV-related M&E and reduce the burden placed on the existing small M&E team which often has to play "catch up" to activities implemented by hundreds of stakeholders without addressing the monitoring of those activities.
2. **Inadequate data dissemination and utilization.** Some progress has been made in this area by convening the MERG, posting of HIV updates on the website, publications, and active engagement of stakeholders in regional or stakeholder meetings. However, progress is hindered by some key factors: inconsistent, incomplete, and late stakeholder reports prohibit meaningful and timely feedback; limited M&E capacity hinders data utilization. This will be addressed by M&E training and additional publications such as HIV bulletins and UNGASS reports. Periodic meetings such as the MERG, National

HIV program reviews, quarterly regional meetings, and national STI meetings will continue to be used as forums for reviewing Indicator data and decision-making.

3. **Slow implementation of information systems:** The current M&E system is largely paper-based. Databases have been developed and are at various stages of testing and implementation. These include a web-based HIV/AIDS Tracking System (HATS), a rapid test database, and an HIV electronic register. Implementation of many data collection tools has lagged behind activities. This will be addressed by further sensitization of partners as well as use of short term consultants to work closely with implementing stakeholders to facilitate implementation of databases and ensure that reports are generated. Further improvement and utilization of these information systems will also enhance the integration of HIV-related M&E with other national data systems.
4. **Inadequate data on some vulnerable groups such as MSM, adolescents, crack/cocaine users and prison inmates:** Despite progress in surveillance of some vulnerable groups such as SW, recent data on other groups are sparse. This includes data on substance abusers, MSM, and out of school youth (street children). Important research questions continue to emerge, in particular the effectiveness of many prevention interventions and the role of outreach testing in behaviour change. Surveillance will be conducted by collaborations with relevant NGOs and line ministries that will facilitate access to these hard to reach populations. Special studies will be conducted to address emerging research questions and evaluate specific prevention interventions.

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