



Geneva, March 2003

*For the use of the Global Fund Secretariat:  
Date Received:  
ID No:*

**PROPOSAL FORM**

**Proposal from Jamaica's Country Co-ordinating  
Mechanism for HIV/AIDS Response (JCCMHAR)**

**A proposal to Scale Up HIV/AIDS Treatment,  
Prevention, and Policy Efforts in Jamaica**

Submitted May 2003

## Acronyms used in Global Fund Proposal

3D	Dedicated to the Development of the Disabled
#	Number
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ARV	Antiretroviral (drugs)
BSS	Behaviour Surveillance Survey
CAREC	Caribbean Epidemiological Centre
CBO	Community Based Organisation
CCM	Country Co-ordinating Mechanism
CDC	Centres for Disease Control
CD	Compact Disk
CHARES	Centre for HIV/AIDS Research, Education and Services
CIDA	Canadian International Development Agency
CIF	Cost, insurance and freight
CSW	Commercial Sex Worker
CVSS	Council of Voluntary Social Services
DFID	Department For International Development (British)
FBO	Faith Based Organisation
GD_	General Documentation (attachment number)
GDP	Gross Domestic Product
GOJ	Government of Jamaica
GTZ	German Technical Corporation
HASD_	HIV/AIDS Specific Documentation (attachment number)
HATS	HIV/AIDS Tracking System
HCL	Health Corporation Limited
HCW	Health Care Worker
HDI	Human Development Index
HFLE	Health and Family Life Education
HIV	Human Immuno-deficiency Virus
IBD	Inter-American Development Bank
IBRD	International Bank for Reconstruction and Development
JAS	Jamaica AIDS Support
JCC	Jamaica Council of Churches
JCCMHAR	Jamaica Country Co-ordinating Mechanism for HIV/AIDS Resource
JCTU	Jamaica Confederation of Trade Unions
JEF	Jamaica Employers Federation
JHPCP	Jamaica HIV/AIDS Prevention and Control Project
JN+	Jamaica Network of Seropositives
KABP	Knowledge, Attitudes, Behaviours, and Practices survey
M&E	Monitoring and Evaluation
MSM	Men who have Sex with Men
MERG	Monitoring and Evaluation Reference Group
MOFP	Ministry of Finance and Planning
MOE	Ministry of Education, Youth and Culture
MOH	Ministry of Health
NA or N/A	Not Applicable
NAC	National AIDS Committee
NAP	National AIDS Programme
NCYD	National Centre for Youth Development
NGO	Non-Governmental Organisation
No.	Number
NPC	National Planning Council
NPHL	National Public Health Laboratory
OI	Opportunistic Infection
OM	Operational Management

- More -

## Acronyms used in Global Fund Proposal continued

OPM	Office of the Prime Minister
OVC	Orphans and Children made Vulnerable by AIDS
PAC	Parish AIDS Committee
PAHO	Pan American Health Organisation
PCR	Polymerase Chain Reaction
PCU	Project Co-ordinating Unit
PIOJ	Planning Institute of Jamaica
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother To Child Transmission
PPP	Per Capita
PSOJ	Private Sector Organisation of Jamaica
RHA	Regional Health Authority
STI	Sexually Transmitted Infection
TB	Tuberculosis
TPDCo	Tourism Product Development Company
TRIPS	Treaty for the Protection of Intellectual Property Rights
UN	United Nations
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific, and Cultural Organisation
UNICEF	United Nations Children's Fund
US	United States
USD	United States Dollars
USAID	United States Agency for International Development
UWI	University of the West Indies
UWI-HARP	University of the West Indies – HIV/AIDS Response Programme
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
YEOs	Youth Empowerment Officers

## SECTION I: Executive summary of Proposal

Please note: The Executive Summary will be used to present an overview of the proposal to various members of the Secretariat, the Technical Review Panel and the Board of the Global Fund. The proposal once approved becomes public information.

TO BE COMPLETED AFTER THE OTHER SECTIONS HAVE BEEN FILLED OUT

### General information:

Table I.a

<b>Proposal title</b> (Title should reflect scope of proposal):	Scaling up HIV/AIDS Treatment, Prevention, and Policy Efforts in Jamaica				
<b>Country or region covered:</b>	Jamaica, West Indies				
<b>Name of applicant:</b>	Jamaica's Country Co-ordinating Mechanism for HIV/AIDS Response (JCCMHAR)				
	<b>2</b>	<b>Government – Health ministry</b>	<b>1</b>	<b>UN/Multilateral agency</b>	
	<b>9</b>	<b>Government – Other ministries</b>	<b>0</b>	<b>Bilateral agency</b>	
	<b>11</b>	<b>NGO/Community-based organisations</b>	<b>1</b>	<b>Academic/Educational Organisations</b>	
	<b>3</b>	<b>Private Sector</b>	<b>2</b>	<b>Religious/Faith groups</b>	
	<b>1</b>	<b>People living with HIV/TB/Malaria*</b>	<b>0</b>	<b>Other (please specify):</b>	
<b>If the proposal is NOT submitted through a CCM, briefly state why:</b>	NA				

Specify which component(s) this proposal is targeting and the amount requested from the Global Fund\*\*:

Table I.b

Component(s) (mark with X):	X		Amount requested from the GF (USD thousands)					Total
			Year 1	Year 2	Year 3	Year 4	Year 5	
	<input checked="" type="checkbox"/>	HIV/AIDS	4,045	3,515	4,549	5,319	5,890	23,319
	<input type="checkbox"/>	Tuberculosis	0	0	0	0	0	0
	<input type="checkbox"/>	Malaria	0	0	0	0	0	0
	<input type="checkbox"/>	HIV/TB	0	0	0	0	0	0
		<b>Total</b>	<b>4,045</b>	<b>3,515</b>	<b>4,549</b>	<b>5,319</b>	<b>5,890</b>	<b>23,319</b>
<b>Total funds from other sources for activities related to proposal</b>			<b>6,440</b>	<b>4,640</b>	<b>4,160</b>			

Please specify how you would like your proposal to be evaluated\*\*\* (mark with X):

\* According to national epidemiological profile/characteristics

\*\* If the proposal is fully integrated, whereby one component cannot be separated from another, and where splitting budgets would not be realistic or feasible, only fill the "Total" row.

<b>The Proposal should be evaluated as a whole</b>	<b>X</b>
<b>The Proposal should be evaluated as separate components</b>	

**Brief proposal summary (1 page) (please include quantitative information where possible):**

- **Describe the overall goals, objectives and main activities per component, including expected results and timeframe for achieving these results:**

The overall goal of the proposal is to strengthen the multi-sector national response to prevent and address the HIV/AIDS epidemic in Jamaica. This will be done through scaling up efforts to:

- provide antiretroviral drugs to both children and adults living with HIV/AIDS;
- promote safer sex practices, including abstinence, especially among sub-populations and marginalised groups who tend to be the most vulnerable; and
- complete and implement policies and a legislative framework specifically addressing stigma and discrimination aimed at PLWHA and vulnerable high-risk groups. An overall national policy, workplace policies, and the structures necessary to pass and implement them are included.

As a result of the work to be funded under the Global Fund grant, Jamaica expects, over the next five years, to establish HIV infection as a chronic disease, with universally used treatment protocols, acceptance by the general community, normalisation in the workplace, and reduction in new HIV infections.

- **Specify the beneficiaries of the proposal per component and the benefits expected to accrue to them (including target populations and their estimated number):**

The chief beneficiaries of this proposal are the estimated (end of 2002) 22,000 people living with HIV/AIDS (PLWHA) in Jamaica and their family members (estimated to be about 100,000 individuals [2002]). The bulk of the request is aimed at scaling up the availability of antiretroviral medicines. The benefit will be longer, healthier lives for PLWHA, which, in turn, will help the stability of the lives of children and others affected by the disease. Other specific efforts planned under this proposal will benefit targeted communities, including youth, the estimated 51,000 men who have sex with men (MSM), and commercial sex workers (CSWs) (8,000-10,000 [2002]). Targeted efforts will focus on the prevention of HIV transmission, with the expected outcome being behaviour change, leading to a reduction in the transmission of HIV within these high-risk groups, as well as the general public (about 170,000 men and 156,000 women [2003]). Underpinning the above programmes is a drive to scale up the efforts to establish a national HIV/AIDS policy and to put in place the necessary governmental and civil society framework (such as workplace policies, line ministry programmes) necessary for the protection of those infected and affected, and vulnerable high-risk groups. The proposal addresses the following cross-cutting issues: gender-specific concerns (male domination, powerlessness of women, role stereotyping), geographic considerations (inner-city, rural, major tourist/resort areas), accommodation for people with disabilities, and reduction of stigma and discrimination. As programmes are scaled up and strengthened, the beneficiaries will grow to include each of these groups. The benefits may be seen in terms of risk reduction, disease prevention, improved medical treatment, stigma reduction, protection of rights and personal empowerment.

- **If there are several components, describe the synergies, if any, expected from the combination of different components (By synergies, we mean the added value the different components bring to each other, or how the combination of**

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\*\*\* This will ensure the proposal is evaluated in the same spirit as it was written. If evaluated as a whole, all components will be considered as parts of an integrated proposal. If evaluated as separate components, each component will be considered as a stand-alone component.

**these components may have effects beyond the effects of each component taken)**

This proposal is for the HIV/AIDS component only because the prevalence of tuberculosis is low in Jamaica and there is no endemic malaria.

- **Indicate if the proposal is to scale up existing efforts or initiate new activities. Explain how lessons learned and best practices have been reflected in this proposal and describe innovative aspects to the proposal**

The proposal scales up the existing efforts of the expanded national response to HIV/AIDS. This response currently involves an impressive array of participants, including persons living with HIV /AIDS, the National HIV/AIDS/STI Programme of the Ministry of Health, the National AIDS Committee, Parish AIDS Committees, line ministries of government, non-governmental organisations, civil society, faith based organisations, the private sector, multilateral partners, and trade unions. The proposal attempts to fill the major gaps of the national response and build on and strengthen existing programmes, primarily in the areas of treatment, care, prevention, and policy development. The proposal intends that these areas will be addressed in a co-ordinated and strategic manner. The JCCMHAR has used a collaborative approach in drafting this proposal, involving representatives from some 30 organisations, including government offices, international organisations, civil society, community and faith-based organisations, NGOs, and individuals, including persons living with HIV/AIDS, in the drafting and review process. Through this approach, the JCCMHAR has been able to take note of strategies that have and have not been successful in the past and determine new directions that key stakeholders believe will be more effective. The agencies named as implementing agencies have expertise in the areas of prevention, treatment, care, advocacy, the development of effective policies, work with PLWHA and vulnerable high-risk groups.

## SECTION II: Information about the applicant

*Table IIa serves to help you know which questions you should answer in this Section, reflecting the different types of application mechanisms and proposals.*

*For further guidance on who can apply, refer to Guidelines Part II.*

Table IIa

Application mechanism	Type of proposal	Questions to answer
National CCM	Country-wide proposal ( <i>Guidelines Para. 10–13</i> )	1–9
Regional CCM	Coordinated Regional proposal from multiple countries reflecting national CCM composition ( <i>Guidelines Para. 27-28</i> )	1–10
	Small Island States proposal with representation from all participating countries but without need for national CCM ( <i>Guidelines Para. 29</i> )	
Sub-national CCM	Sub-national proposal ( <i>Guidelines Para. 30</i> )	1–9 and 11
Non-CCM	In-country proposal ( <i>Guidelines Para. 31-35</i> )	12 – 16
Regional Non-CCM	Regional proposal ( <i>Guidelines Para. 34</i> )	12 – 15 and 17

*Proposals from countries in complex emergencies will be dealt with on a case-by-case basis (Guidelines Para. 35)*

### **Country Coordinating Mechanism (CCM)**

Table IIb

Preliminary questions	(Yes/No)
<b>a). Has the CCM applied to the Fund in previous rounds?</b>	No
<b>b). Has the composition of the CCM changed since the last submission?</b>	NA
<b>c). If composition of CCM has changed, briefly outline changes (e.g., list of new members or sector representatives):</b>	NA

- 1. Name of CCM** (e.g., CCM Country name, National Committee to fight AIDS, TB and Malaria, etc):

Jamaica's Country Co-ordinating Mechanism for HIV/AIDS Response (JCCMHAR)

- 2. Date of constitution of the current CCM** (The date the CCM was formed for the purpose of the Global Fund application. If the CCM builds on or uses existing processes – which is encouraged – please explain this in Question 3):

February 14, 2003

- 3. Describe the background and the process of forming the CCM** (including whether the CCM is an entirely new mechanism or building on existing bodies, how the other partners were contacted and chosen, etc.):

At its inception, Jamaica's Country Co-ordinating Mechanism for HIV/AIDS Response (JCCMHAR), was the Executive of the National AIDS Committee. Today, the JCCMHAR is an independent, fluid, multi-sectoral body chaired by a senior government official, and represents a wide cross-section of civil society, including community based initiatives and people living with HIV/AIDS. The Global Fund to Fight AIDS, Tuberculosis and Malaria was first presented to the Executive of the National AIDS Committee in November 2002. The Committee was informed that a Country Co-ordinating Mechanism would need to be in place in-country to help facilitate and co-ordinate the preparation, implementation, monitoring, and evaluation of a submitted and approved

proposal. The Executive voted unanimously to act as the initial members of the Country Co-ordinating Mechanism but stressed the need to expand the membership base to adequately represent persons living with HIV/AIDS and civil society. Additional representation was sought, notably from Artistes Against AIDS, Journalists Against AIDS, the Council of Voluntary Social Services (CVSS), the Policy Support Unit of the Office of the Prime Minister, the Planning Institute of Jamaica, Bureau of Women's Affairs, the Private Sector Organisation of Jamaica, and the Jamaica Employers Federation. The JCCMHAR was officially constituted on February 14, 2003

**3.1. If the CCM is or includes an already existing body, briefly describe the work previously done, programmes implemented and results achieved:**

The National AIDS Committee (NAC) is a private non-governmental organisation that was established in 1988 by the Minister of Health to co-ordinate the national multi-sectoral response to the HIV/AIDS epidemic in Jamaica. Today, the National AIDS Committee is an umbrella organisation representing over 100 non-governmental, community, and faith based organisations with direct reporting responsibilities to the National Planning Council, chaired by the Minister of Finance. The Committee has three sub-committees: Education, Care and Counselling, and Fundraising. The Committee is represented within communities by Parish-based Parish AIDS Associations (sometimes referred to as Parish AIDS Committees). These Associations are all-volunteer groups constituted as limited liability companies. They lead the HIV/AIDS efforts at the community level and provide invaluable feedback to the NAC on the experiences of communities in the fight against HIV/AIDS and the support and care of persons infected with and affected by HIV/AIDS. The National AIDS Committee is principally responsible for the following:

- To formulate policy and establish national response priorities;
- To take the lead in the national planning relative to HIV/AIDS issues;
- To spearhead advocacy relative to HIV/AIDS;
- To mobilise HIV/AIDS resources and monitor their allocation and utilisation;
- To foster linkages among affected stakeholders;
- To act as a clearinghouse for information.

The most notable achievements to date include: providing a forum for co-ordinating and networking, providing public education, and fundraising for HIV/AIDS efforts island-wide; a review of legal, ethical and human rights issues for persons living with and affected by HIV/AIDS (PLWHA), advocacy for the development of workplace policies, strengthening the community response to HIV/AIDS, providing assistance to PLWHA, supporting the development of networks of people living with HIV/AIDS and, most recently, the development of a National Plan of Action for Jamaican children orphaned or otherwise made vulnerable by HIV/AIDS (OVC) (2003).

**4. Describe the organisational processes (e.g., secretariat, sub-committee, stand-alone; describe the decision-making mechanism. Provide Terms of Reference, operating rules or other relevant documents as attachments), (1 paragraph):**

The JCCMHAR is an independent body. Decision-making is based on the principle of equal representation and consensus in decision making and the active and full participation of its members. JCCMHAR is chaired by a senior government official. Meetings are hosted quarterly, with extraordinary meetings when the need arises.

**5. Describe the mode of operation of the CCM (e.g., frequency of meetings, functions and responsibilities of the CCM. Provide the minutes or records of previous meetings as attachments), (1 paragraph):**

The JCCMHAR meets on a quarterly basis at the National AIDS Committee offices, unless a need arises for an extraordinary meeting. The principle functions of the JCCMHAR at present are as follows:

- To co-ordinate and support the development of a proposal to the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria.
- To monitor and evaluate an approved proposal to the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria;
- To inform and update members of the JCCMHAR with relevant information as the need arises;
- To document best practises;
- To write and share reports on the progress made in addressing HIV/AIDS in-country;
- To aggressively and directly address the gaps identified in the National Response to effect real change for civil society, the disenfranchised, and persons living with HIV/AIDS.

**6. Describe plans to enhance the role and functions of the CCM in the next 12 months, including plans to promote partnerships and broader participation as well as communicating with wider stakeholders, if required (1 paragraph):**

Over the next 12 months, the following will be put in place to address the functional needs of the JCCMHAR.

- Defined and accepted terms of reference for members of the JCCMHAR;
- A defined and accepted organisational chart with clear outputs and reporting mechanisms;
- The development of clear channels of information dissemination;
- Change meetings from quarterly to bi-monthly, and establish consistent attendance and active participation.

**7. Members of the CCM**

*Please note: All representatives of organisations included in the CCM must sign this page to be included in the original, hard-copy proposal sent to the Secretariat. The signatures must reach the Secretariat before the deadline for submitting proposals.*

*Please print additional pages if necessary, including the following statement:*

Duplicates of these pages, with the actual signatures, have been scanned and will be sent as an attachments.

**“We the undersigned hereby certify that we have participated throughout the CCM process and have had sufficient opportunities to influence the process and this application. We have reviewed the final proposal and are happy to support it. We further pledge to continue our involvement in the CCM if the proposal is approved and as it moves to implementation”**

Table II.7

Agency/Organisation (including type*)	Name of representative	Title	Date	Signature
Artists Against AIDS Cultural group	Mr. Patrick Barrett	Chairman		
<b>Main role in CCM</b>				
Artistes Against AIDS is a group of Jamaican entertainers (singers, musicians and others in the Jamaican music industry) who are utilising their talents to promote safer sex, abstinence, and to reduce stigma attached to persons with HIV/AIDS. They will play an unequivocal role in promoting the work of the CCM in popular culture and to large audiences.				

Agency/Organisation (including type*)	Name of representative	Title	Date	Signature
Journalists Against AIDS Community Based Initiative	Ms. Patricia Watson	Chair		
<b>Main role in CCM</b>				
Journalists Against AIDS (JAAIDS) is a media based, advocacy group in Jamaica. As a member of the JCCMHAR, this organisation will enhance the quality of media reporting on HIV/AIDS, reproductive health issues, and advocacy for the rights of persons living with HIV/AIDS, and encourage informed discussion on issues related to HIV/AIDS.				

Agency/Organisation (including type*)	Name of representative	Title	Date	Signature
University of the West Indies HIV/AIDS Response Programme (UWI Harp) Academic Institution	Professor Brendan Bain	Chairman		
<b>Main role in CCM</b>				
The UWI Harp mission states that it will build and harness the capacity of the university to contribute to the regional and international efforts to mitigate the impact of the HIV/AIDS epidemic, firstly in the University, and then on the wider society. As a member of the JCCMHAR, UWI Harp will ensure that the University of the West Indies is fully participating in the national response to the HIV/AIDS epidemic.				

\*  
E.g. People living with HIV/TB/malaria, NGOs/Community-based organisations, Private Sector, Religious/Faith-based groups, Academic/Educational Sector, Government Sector.

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<b>Agency/Organisation (including type*)</b>	<b>Name of representative</b>	<b>Title</b>	<b>Date</b>	<b>Signature</b>
The Council of Voluntary Social Services  Not for profit umbrella organisation. Limited Company by guarantee	Mrs. Winsome Wilkins	Chief Executive Officer		

**Main role in CCM**

The Council of Voluntary Social Services is a national, non-profit umbrella organisation. It represents organisations in four sectors: youth, women, the community, and health. The Council has more than 100 members and actively builds the capacity of members and the wider community through training programmes. One such example is the Diploma in NGO Management, run by the Council in collaboration with the University of the West Indies School of Continuing Studies. The Council represents the concerns of the social sector at national and international levels and will ensure, through representation on the JCCMHAR, that all social service organisations are participating in the national response to HIV/AIDS in Jamaica.

<b>Agency/Organisation (including type*)</b>	<b>Name of representative</b>	<b>Title</b>	<b>Date</b>	<b>Signature</b>
Policy Analysis and Review Unit, Office of the Prime Minister  Government	Mrs. Ann-Marie Bonner	Principal Director		

**Main role in CCM**

The Policy Analysis and Review Unit, Office of the Prime Minister, adds strategic value to the decision-making processes of the Cabinet through the provision of high quality policy advice, information, assessments, policy capacity development, and co-ordinating and facilitating support services. It is anticipated that its experiences will add strategic value to the work of the CCM and strengthen the political commitment to address the rights of persons living with HIV/AIDS.

<b>Agency/Organisation (including type*)</b>	<b>Name of representative</b>	<b>Title</b>	<b>Date</b>	<b>Signature</b>
Jamaica Council of Churches  Faith Based Organisation	Dr. Howard Gregory	President		

**Main role in CCM**

To support and care for persons living with and affected by HIV/AIDS by providing spiritual support through counselling, education, material dissemination, and sensitisation sessions.

E.g. People living with HIV/TB/malaria, NGOs/Community-based organisations, Private Sector, Religious/Faith-based groups, Academic/Educational Sector, Government Sector

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Agency/Organisation (including type*)	Name of representative	Title	Date	Signature
Planning Institute of Jamaica Government	Mr. Walter James	Economist/ Sociologist - Health		
<b>Main role in CCM</b>				
The Planning Institute of Jamaica is committed to leading the process of policy formulation on economic and social issues and external co-operation and management to achieve sustainable development for the people of Jamaica. The Institute will, therefore, provide comprehensive and technically sound guidance to the workings of the JCCMHAR, especially in the area of policy development.				

Agency/Organisation (including type*)	Name of representative	Title	Date	Signature
Private Sector Organisation of Jamaica Private Sector	Mr. Matthew Pragnell	Alternate PSOJ HIV/ AIDS Representative		
<b>Main role in CCM</b>				
To develop and support workplace policy development within the private sector. These policies address such things as discrimination and stigma against persons living with and affected by HIV/AIDS.				

Agency/Organisation (including type*)	Name of representative	Title	Date	Signature
Public Defender Ombudsman (political appointment and Chair, National AIDS Committee)	Mr. Howard Hamilton QC	Public Defender/ Chair, National AIDS Committee		
<b>Main role in CCM</b>				
The Public Defender's Office is spearheading the advocacy efforts for the rights of persons living with and/or affected by HIV/AIDS, and the development of policies aimed at their protection and wellbeing.				

Agency/Organisation (including type*)	Name of representative	Title	Date	Signature
National HIV/AIDS Control Programme Government	Dr. Peter Figueroa	Chief, Epidemiology/ AIDS		
<b>Main role in CCM</b>				
The National HIV/AIDS Control Programme provides the technical and programmatic support to the JCCMHAR. The development of a National Strategic Plan on HIV/AIDS 2002-2006 was led by the National Response Programme on HIV/AIDS. This Strategic Plan was a follow-up to the previous 1997-2001 Medium Term Plan and took into account an expanded response to HIV/AIDS in the region. Dr. Figueroa is chair of the CCM.				

E.g. People living with HIV/TB/malaria, NGOs/Community-based organisations, Private Sector, Religious/Faith-based groups, Academic/Educational Sector, Government Sector

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Agency/Organisation (including type*)	Name of representative	Title	Date	Signature
UN Theme Group  Multi-Lateral Partner	Ms. Laila Ismail-Khan	Chair		

**Main role in CCM**

The Integrated UN Theme Group on HIV/AIDS in Jamaica maximises the effectiveness and impact of UN partners on HIV/AIDS in Jamaica. The UN Theme Group provides the opportunity for collaboration and division of labour, based on specific mandates and comparative advantage.

Agency/Organisation (including type*)	Name of representative	Title	Date	Signature
Hope World Wide, Jamaica and Education Sub-Committee, National AIDS Committee  Non-governmental organisation	Mr. Simon Harris	Chair, Education Sub-Committee		

**Main role in CCM**

The sub-committee is responsible for the dissemination of information to the public, and to monitor the educational activities of all agencies involved in HIV/AIDS/STI education.

Agency/Organisation (including type*)	Name of representative	Title	Date	Signature
Kingston and St. Andrew Parish AIDS Committee and Care and Counselling Sub-Committee, National AIDS Committee  Non-governmental organisation	Rev. Patrick Cunningham	Chair, Kingston St. Andrew Parish AIDS Committee and Chair, Care and Counselling Sub-Committee		

**Main role in CCM**

To provide training for persons involved in care and support. Through facilitation and collaboration, improve the quality of life for people living with HIV/AIDS.

Agency/Organisation (including type*)	Name of representative	Title	Date	Signature
Business entrepreneur and Fund-raising Sub-committee, National AIDS Committee  Non-governmental organisation	Mrs. Rose Tavares-Finson	Chair, Fundraising Sub-Committee		

**Main role in CCM**

To ensure the NAC's effective use of funds, and ensuring the continued support to persons living with or affected by HIV/AIDS.

E.g. People living with HIV/TB/malaria, NGOs/Community-based organisations, Private Sector, Religious/Faith-based groups, Academic/Educational Sector, Government Sector.

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Agency/Organisation (including type*)	Name of representative	Title	Date	Signature
Ministry of Local Government and Community Development  Government	Ms. Onika Campbell	Director, Policy, Planning, and Evaluation		
<b>Main role in CCM</b>				
To participate in the national response to HIV/AIDS as it relates to local community mobilisation, reducing stigma and discrimination, and improving the capacity of the community to address issues that make persons vulnerable to HIV infection.				

Agency/Organisation (including type*)	Name of representative	Title	Date	Signature
Ministry of Labour and Social Security  Government	Mr. Neville Moodie	Director, Industrial Safety		
<b>Main role in CCM</b>				
To participate in the national response to HIV/AIDS as it relates to the workforce, especially mobile populations, i.e. farm workers.				

Agency/Organisation (including type*)	Name of representative	Title	Date	Signature
Ministry of Tourism and Sport, Tourism Product Development Company (TPDCo)  Government	Mrs. Mary Helen Reece	Director of Standards		
<b>Main role in CCM</b>				
To participate in the national response to HIV/AIDS through implementation of policies, training, awareness programmes, and institute preventative measures for the employees within the tourism industry.				

Agency/Organisation (including type*)	Name of representative	Title	Date	Signature
Ministry of Education, Youth, and Culture  Government	Dr. Delores Brissett	Assistant Chief Education Officer		
<b>Main role in CCM</b>				
To participate in the national response to HIV/AIDS by empowering the school community with the knowledge and skills necessary to initiate and sustain healthy relationships that are aimed at reducing vulnerability to HIV/AIDS/STI.				

\* E.g. People living with HIV/TB/malaria, NGOs/Community-based organisations, Private Sector, Religious/Faith-based groups, Academic/Educational Sector, Government Sector.

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<b>Agency/Organisation (including type*)</b>	<b>Name of representative</b>	<b>Title</b>	<b>Date</b>	<b>Signature</b>
National Centre for Youth Development  Government	Mr. Ohene Blake	Director		
<b>Main role in CCM</b>				
To participate in the national response to HIV/AIDS by empowering youth to actively participate in the shaping of the environment necessary for their development. This embraces increasing access to information related to HIV/AIDS education and prevention, including services that will promote the development of knowledge and life skills.				

<b>Agency/Organisation (including type*)</b>	<b>Name of representative</b>	<b>Title</b>	<b>Date</b>	<b>Signature</b>
Ministry of National Security  Government	Ms. Angela Buchanan	Senior Director, Programme Management and Co- ordination Division		
<b>Main role in CCM</b>				
To participate in the national response to HIV/AIDS as it relates to work within the correctional services and the protection of persons' rights.				

<b>Agency/Organisation (including type*)</b>	<b>Name of representative</b>	<b>Title</b>	<b>Date</b>	<b>Signature</b>
Jamaica Confederation of Trade Unions (J.C.T.U)  Trade Union	Ms. Lilieth Harris	Executive Director		
<b>Main role in CCM</b>				
To advocate for and support the rights of persons within the workforce living with and affected by HIV/AIDS. The JCTU will participate and support the development and implementation of appropriate HIV/AIDS workplace policies, education and awareness programmes that aim to address HIV/AIDS prevention and management				

E.g. People living with HIV/TB/malaria, NGOs/Community-based organisations, Private Sector, Religious/Faith-based groups, Academic/Educational Sector, Government Sector.

**“We the undersigned hereby certify that we have participated throughout the CCM process and have had sufficient opportunities to influence the process and this application. We have reviewed the final proposal and are happy to support it. We further pledge to continue our involvement in the CCM if the proposal is approved and as it moves to implementation”**

<b>Agency/Organisation (including type*)</b>	<b>Name of representative</b>	<b>Title</b>	<b>Date</b>	<b>Signature</b>
Jamaica Network of Seropositives (JN+)  Non-Governmental Organisation/persons living with AIDS	Ms. Olive Edwards	Acting Executive Director		
<b>Main role in CCM</b>				
The involvement of persons living with HIV/AIDS is important to the success of any intervention or programme to address the HIV epidemic. The Jamaica Network of Seropositives (JN+) advocates for the rights and concerns of people living with and affected by HIV/AIDS through partnership, empowerment, and resource mobilisation. This is an organisation made up primarily of persons living with AIDS and, as such, is the primary representative of this community.				

<b>Agency/Organisation (including type*)</b>	<b>Name of representative</b>	<b>Title</b>	<b>Date</b>	<b>Signature</b>
Jamaica AIDS Support  Non-Governmental Organisation	Mr. Ian McKnight	Acting Executive Director		
<b>Main role in CCM</b>				
As a member of the JCCMHAR, Jamaica AIDS Support brings with it a decade's experience as a lead non-governmental organisation involved in HIV/AIDS work in Jamaica. The organisation is involved in care, prevention and targeted interventions and has three offices: Kingston, St. Andrew; Ocho Rios, St. Ann; and Montego Bay, St. James. These offices cover the most populous areas, and the areas with the highest HIV prevalence rates. It has a history of reaching vulnerable high-risk groups such as MSM, CSWs and PLWHA with effective programmes.				

<b>Agency/Organisation (including type*)</b>	<b>Name of representative</b>	<b>Title</b>	<b>Date</b>	<b>Signature</b>
Bureau of Women's Affairs  Government	Dr. Glenda Simms	Executive Director		
<b>Main role in CCM</b>				
The Bureau of Women's affairs is the government agency responsible for enhancing the status of women. It exists as an institutional mechanism for the advancement of women through the translation of policies into programmes, and linking goals to relevant ministries. In 2001, women accounted for 46% of the total reported cases of AIDS, with an increase of 10% from the previous year. It is, therefore, imperative that the CCM include women's representatives in the national response.				

E.g. People living with HIV/TB/malaria, NGOs/Community-based organisations, Private Sector, Religious/Faith-based groups, Academic/Educational Sector, Government Sector.

**“We the undersigned hereby certify that we have participated throughout the CCM process and have had sufficient opportunities to influence the process and this application. We have reviewed the final proposal and are happy to support it. We further pledge to continue our involvement in the CCM if the proposal is approved and as it moves to implementation”**

<b>Agency/Organisation (including type*)</b>	<b>Name of representative</b>	<b>Title</b>	<b>Date</b>	<b>Signature</b>
Parish AIDS Associations Southern Regional				
Western Regional	Mr. Trevor Palmer	Regional Representative		
North - East Regional	Ms. Claudet Stupart	Regional Representative		
South – East Regional	Nurse Dorret Norrine	Regional Representative		
Community Based Organisations	Ms. Paulet Byrd	Regional Representative		
<b>Main role in CCM</b>				
Parish AIDS (Committees) Associations formed in all of Jamaica’s parishes as communities began to respond to HIV/AIDS. These voluntary bodies do educational outreach work, care and support of those affected by and infected with HIV/AIDS, and draw together private and public sector representatives in the community-based response to HIV /AIDS.				

<b>Agency/Organisation (including type*)</b>	<b>Name of representative</b>	<b>Title</b>	<b>Date</b>	<b>Signature</b>
The Jamaica Employers Federation	Mrs. Jacqueline Coke-Lloyd	Executive Director		
Employers Group				
<b>Main role in CCM</b>				
To advocate for and support the rights of employers in fighting the further spread of HIV/AIDS and its related stigma and discrimination				

E.g. People living with HIV/TB/malaria, NGOs/Community-based organisations, Private Sector, Religious/Faith-based groups, Academic/Educational Sector, Government Sector.

**7.1 Provide as attachment the following documentation for private sector and civil society CCM members:**

- **Statutes of organisation** (official registration papers)
- **A presentation of the organisation, including background and history, scope of work, past and current activities**
- **Reference letter(s), if available**
- **Main sources of funding**

Please see attachment GD8.

**7.2 If a CCM member is representing a broader constituency, please provide a list of other groups represented.**

A member list for each of the following organisations is attached as attachment GD9.

**8. Chair of the JCCMHAR and alternate Chair or Vice-Chair**

*Table II.8*

	<b>Chair of CCM</b>	<b>Alternate Chair/Vice-Chair</b>
<b>Name</b>	Dr. Peter Figueroa	Dr. Yitades Gebre
<b>Title</b>	Chief, Epidemiology/AIDS	Executive Director Project Co-ordination Unit (GOJ/World Bank)
<b>Address</b>	National HIV/AIDS/STI Control Programme Ministry of Health 4 <sup>th</sup> Floor 2-4 King Street KingstonJamaica	National HIV/AIDS/STI Control Programme Ministry of Health 4 <sup>th</sup> Floor 2-4 King Street Kingston Jamaica
<b>Telephone</b>	(876) 967-1100 / 1105 (876) 948-3548 (Direct Line)	(876) 967-1100 / 1105 (876) 922-2448 (Direct Line)
<b>Fax</b>	(876) 967-1643	(876) 967-1643
<b>E-mail</b>	figueroap@moh.gov.jm	gebrey@moh.gov.jm
<b>Signature</b>		

**9. Contact persons for questions regarding this proposal** (please provide full contact details for two persons – this is necessary to ensure expedient and responsive communications):

*Please note: The persons below need to be readily accessible for technical or administrative clarification purposes by the Secretariat or the TRP members.*

Table II.9

	<b>Primary contact</b>	<b>Second contact</b>
<b>Name</b>	Dr. Peter Figueroa	Dr. Yitades Gebre
<b>Title</b>	Chief, Epidemiology/AIDS	Executive Director, Project Co-ordination Unit (GOJ/World Bank)
<b>Address</b>	National HIV/AIDS Control Programme Ministry of Health 4 <sup>th</sup> Floor 2-4 King Street Kingston Jamaica	National HIV/AIDS Control Programme/Project Co-ordination Unit Ministry of Health 4 <sup>th</sup> Floor 2-4 King Street Kingston Jamaica
<b>Telephone</b>	(876) 967-1100 / 1105 (876) 948-3548 (Direct Line)	(876) 967-1100 / 1105 (876) 922-2448 (Direct Line)
<b>Fax</b>	(876) 967-1643	(876) 967-1643
<b>E-mail</b>	figueroap@moh.gov.jm	gebrey@moh.gov.jm

- 10. For coordinated regional proposals and Small Island States proposals describe how submitting this regional proposal adds value beyond the national level / what a national proposal could achieve (1 paragraph):**

NA

- 10.1. For coordinated regional proposals, provide evidence of support from the national CCM or, if there is none, from other relevant national authority as attachment (e.g., letter of endorsement from Chair/Alternate of CCM or equivalent documentation and minutes of meeting that reflect CCM endorsement).**

NA

- 11. Sub-national Proposal from Large Countries**

- 11.1. Explain why a sub-national CCM mechanism has been chosen (1 paragraph):**

NA

- 11.2. Describe how this proposal is consistent and fits with nationally formulated policies and/or how it fits with the national CCM plans (1 paragraph):**

NA

- 11.3. Provide evidence of support from the national CCM or, if there is none, from other relevant national authority as attachment.**

NA

**Non-CCM applicant**

- 12. Name of applicant:**

NA

13. Representative of organisation applying: NA

Table II.13

	Representative	Alternate
Name		
Title		
Address		
Telephone		
Fax		
E-mail		

14. Contact persons for questions regarding this proposal (please provide full contact details for two persons – this is necessary to ensure expedient and responsive communications): NA

*Please note: The persons below need to be readily accessible for technical or administrative clarification purposes by the Secretariat or the TRP members.*

Table II.14

	Primary contact	Secondary contact
Name		
Title		
Address		
Telephone		
Fax		
E-mail		

15. Description of applying organisation NA

15.1. Indicate what type of organisation the applicant is (mark with X): NA

Table II.15.1

<input type="checkbox"/>	<b>Non-Governmental Organisation (NGO) or network of NGOs</b>
<input type="checkbox"/>	<b>Community based Organisation (CBO) or network of CBOs</b>
<input type="checkbox"/>	<b>Private Sector</b>
<input type="checkbox"/>	<b>Academic/ Educational Sector</b>
<input type="checkbox"/>	<b>Faith-based Organisation</b>
<input type="checkbox"/>	<b>Regional Organisation</b>
<input type="checkbox"/>	<b>Other (please specify):</b>

15.2. Provide as attachment the following documentation: NA

- Statutes of organisation (official registration papers)
- A presentation of the organisation, including background and history, scope of work, past and current activities
- Reference letter(s), if available
- Main sources of funding

16. Justification for applying outside the CCM NA

16.1. Indicate reasons for not applying through the CCM (Explain clearly the circumstances, conditions and reasons) (1–2 paragraphs):

NA

16.2. Have you been in contact with the CCM in your country or other relevant governmental agencies (e.g., Ministry of Health, National AIDS Council)? If so, what was the outcome? If not, why?

NA

**16.3 Include letters from supporting organisations (e.g. human rights groups, NGO networks, bilateral or multilateral organisations, etc) supporting your reasons for not applying through a CCM as attachment.**

NA

- 17. For regional proposals from Regional Organisations or International Non Governmental Organisations, describe how submitting this regional proposal adds value beyond the national level / what a national proposal could achieve (1 paragraph):**

NA

**17.1. Provide signed letters of endorsement from the national CCMs or, if there is none, from other relevant national authority for the countries covered by the proposal as attachment.**

NA

## SECTION III: General information about the country setting

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*Please note: For **regional proposals**, the information requested in this section should reflect the situation in all countries involved, either in an aggregated form or by individual country.*

*For **sub-national proposals**, the information requested should reflect the situation in the particular sub-national area within the overall country context.*

*For further guidance, refer to Guidelines Part III*

### **18. Describe the burden or potential burden of HIV/AIDS, TB and /or Malaria:**

(Describe current epidemiological data on prevalence, incidence or magnitude of the diseases; its current status or stage of the diseases; major trends of the diseases disaggregated by geographical locations and population groups, where this data is available and/or relevant) (1 – 2 paragraphs per disease covered in proposal):

With an HIV prevalence rate of 2.3% (2003), the Caribbean is the region hardest hit by the epidemic outside Sub-Saharan Africa. Jamaica is one of the Caribbean countries where the epidemic has spread from high-risk groups to the general population. It is estimated that around 1-1.5% of the adult population, or 22,000 to 25,000 people, are living with HIV/AIDS in Jamaica. This represents the third largest population of people living with HIV/AIDS (PLWHA) in the Caribbean, after Haiti and the Dominican Republic. In Jamaica, reported HIV prevalence is highest in tourism/resort areas, such as St. Ann and St. James, where prevalence rates among antenatal clinic (ANC) attendees are 2.6% and 3.0% (2002) respectively. Kingston, the capital city, also has high ANC attendee HIV seroprevalence, of about 2.5% (2002). In Jamaica, HIV transmission is predominantly through heterosexual contact. Intravenous drug use has not been reported as a significant transmission route of the HIV virus in Jamaica, although it should be noted that crack-cocaine is widely used in inner-city communities and alcohol use is prevalent. It must be noted that substance abusers are a focus of the wider national HIV/AIDS response but are not a focus of this proposal. A national campaign to prevent mother to child transmission (PMTCT) is presently being addressed by the wider national HIV/AIDS response. Since Jamaica's first AIDS case in 1982, a total of 7,029 AIDS cases have been reported (to the end of 2002), of which 50% were recorded in the last four years. It is known that HIV incidence is high among young people and women. HIV surveillance has shown higher prevalence of HIV among the young: 1.63% and 2.43% in the 15-19 and 25-29 age groups (end of 2002). Lack of access to antiretrovirals, compounded by inadequate nutrition and untreated opportunistic infections, result in a high annual case mortality rate. In 2002 alone, 692 AIDS deaths were reported, representing an annual case mortality rate of 60%. This has been a consistent average mortality rate (1982- 2002). Given that 85% of HIV/AIDS cases occur among individuals who are in their productive years (ages 20 to 59), there is almost a direct correlation between infection and economic duress at the household level. A study carried out by CAREC /UWI in 1999 estimated that Jamaica's Gross Domestic Product could fall as much as 6.5% if the current HIV prevalence rates are not addressed. In addition, a recent rapid assessment of orphans and other children made vulnerable by HIV/AIDS (2002) in Jamaica estimated that there may be as many as 50,000 children affected by a parent's or caregiver's infection.

### **19. Describe the current economic and poverty situation (Referring to official indicators such as GNP per capita, Human Development Index (HDI), poverty indices, or other information on resource availability; highlight major trends and implications of the economic situation in the context of the targeted diseases) (1–2 paragraphs):**

The Human Development Report 2002 ([www.undp.org](http://www.undp.org)) ranks Jamaica 86th of 173 countries on the human development index (HDI). More importantly, the Report indicates that Jamaica is one of only two countries with a real per capita income that was lower in 2000 (PPP US\$3,639) than it was in 1975 (PPP US\$3,981). The debt to GDP ratio in 2001 was 136%, and with debt servicing obligations consuming in excess of 60% of the national budget, very few resources are available for the social sector, including the health sector.

In light of these factors, efforts to reduce poverty and unemployment have been severely constrained. While the country recorded a dramatic reduction in rates of poverty between 1995 (27.5%) and 2001 (16.9%), preliminary reports indicate that there will be a reversal of this trend in 2002.<sup>†</sup> Given the close relationship between poverty and HIV/AIDS, it is evident that Jamaica must look to outside sources for assistance in scaling up its HIV/AIDS efforts.

In terms of unemployment, not only does the average rate of unemployment continue to be high, but the clear gender differences between females (21% unemployment) and males (10.3%) persist. Also, female-headed households continue to show the highest incidence of poverty. These two factors have clear implications for HIV/AIDS, given the unequal negotiating power of men and women in the society, and the fact that in recent years the rate of increase in HIV infection has been considerably faster for females than for males. Jamaica's current level of crime and violence rates among the highest in the world. Seventy percent of the crimes are committed by youths (36% for the age group 20-25 yrs. and 20% for 26-30 yrs.) living in inner city communities, where the urban poor reside. Violence against women, including rape, is also at an intolerably high level. Crime and HIV/AIDS, therefore, now form a deadly duo, robbing the nation of much of its human resources. Despite severe constraints imposed by lack of progress in development, the Government of Jamaica does have the capacity to finance a slowly growing share of total commitments needed to finance an adequate response in the fight against HIV/AIDS. Global Fund support at the beginning of this renewed effort, will help bridge the period that the Government of Jamaica needs before it can more fully commit its own resources to the challenges of HIV/AIDS.

**20. Describe the current political commitment in responding to the diseases**

(indicators of political commitment include the existence of inter-sectoral committees, recent public pronouncements, appropriate legislations, etc.) (1–2 paragraphs):

The Government of Jamaica (GOJ) has indicated its strong commitment in responding to HIV/AIDS, but there is more that needs to be done. Some of the actions that indicate a high level of commitment include:

(a) Parliament approved the National Strategic Plan for HIV/AIDS (2002-2006);

(b) The Government of Jamaica agreed to use the National Planning Council (NPC), chaired by the Minister of Finance, as a high-level forum for discussing/advising on HIV/AIDS. The NPC comprises Cabinet members, business leaders, and leaders from civil and religious society. The profile of the National AIDS Committee (NAC) has been elevated to a Working Group of the NPC on HIV/AIDS;

(c) Cabinet has issued a mandate to key line ministries to prepare and implement HIV/AIDS work programmes within their sectors and to report regularly to Cabinet on progress;

(d) A Monitoring and Evaluation plan and unit have been established within the Ministry of Health to monitor progress on HIV/AIDS programmes. As noted in the section on monitoring and evaluation (Section VII), this structure will provide the foundation for monitoring and evaluating projects under the Global Fund

(e) Other major efforts have been in reducing prices for antiretroviral drugs, negotiating a large World Bank loan, working with other Caribbean nations in developing Global Fund proposals and other HIV/AIDS initiatives.

**21. Countries classified as “Lower-Middle Income” or “Upper-Middle Income” by the World Bank are eligible to apply only if they meet additional requirement (Guidelines Para 8). The sections below are required for proposals from these countries.**

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<sup>†</sup> The Minister of Finance in his 2003 budget presentation indicated that the rate for 2002 would be over 18%.

**21.1 Co-financing: describe in both narrative and quantitative terms how domestic or external resources will be used to co-finance the activities described in this proposal, indicating the source and the extent of co-financing (i.e., what percentage of the budget for the proposal is covered by other resources and what percentage is being requested from the Global Fund) (2–3 paragraphs)**

Jamaica benefits from multi-lateral finance (World Bank, Inter-American Development Bank, UN Agencies) and technical (UNAIDS and its partners) assistance and bilateral (USAID), and other grant assistance. The Government of Jamaica now perceives the need to scale up its financing support for HIV/AIDS programmes from its own revenue sources. Over the course of the proposed grant period, the Government of Jamaica will gradually increase its co-financing of HIV/AIDS programmes in evidence of the high priority it attaches to the fight against HIV/AIDS.

Under the Global Fund proposal, the Government of Jamaica will focus on poor households that have been impacted by HIV/AIDS. The government further recognises that AIDS can, itself, be a primary cause of poverty and diminution of future earning power. Policies that aim to secure lower prices for antiretroviral drugs can help both poor households benefiting from public subsidy and better-off Jamaican households that would otherwise be forced to pay exorbitant prices for privately-procured antiretroviral drugs.

**21.2. Focus on poor or vulnerable populations: describe how underserved populations of poor and vulnerable groups will be targeted by the proposal (2–3 paragraphs)**

Implementing agencies of the Global Fund proposal will be developing programmes to scale up current efforts in treatment, care, prevention, and policy. Under treatment, the major focus will be on providing antiretroviral drugs for PLWHA. This will have a multifaceted effect of

- Improving the health of those most directly affected by the disease. There are an estimated 4,000 to 6,000 children and adults in Jamaica living with AIDS who need ARV therapy. Not all PLWHA need to be on antiretrovirals, but, while the Government of Jamaica has been working diligently to reduce the prices of the drugs, many people who do need them still cannot afford them;
- Allowing PLWHA to remain healthy and able to earn an income, rather than becoming dependent on social and poor relief services; and
- Reducing the number of children who become orphans or who are vulnerable to economic and other ills as a result of their parents' sickness. The number of children estimated to be included in this category in Jamaica today is 50,000 (2002 study). Many of these children are living in poverty and being subjected to emotional, physical and mental pressures far beyond their years. In fact, according to UNICEF/Jamaica, children make up half of all Jamaicans living in poverty. AIDS will impact this situation with the creation of many more orphans and vulnerable children.

Within prevention, the JCCMHAR will be filling gaps in efforts focused on poor and high-risk groups, including:

- youth (young people 15 to 24, in and out of school, in rural and urban settings);
- commercial sex workers (CSWs) and their clients;
- men who have sex with men (MSM) and their partners;
- people with disabilities;
- the poor; and

- persons living with HIV/AIDS (PLWHA), their partners and family members.

Implementing agencies will be developing materials and conducting interventions aimed specifically at addressing the needs of these populations. While Jamaica has been working with some of these vulnerable high-risk populations for many years, such as CSWs and MSM, efforts to reach them need to intensify, especially in tourism/resort areas. Jamaica also must focus attention on CSWs in non-tourism areas, which have not been targeted for interventions in the traditional sense. Other populations are just coming to the fore in relation to HIV/AIDS in Jamaica, such as persons with disabilities and family members of PLWHA. The implementing agencies will need to conduct baseline studies to assess the full scope of their needs, and assess the most effective tools for communication and behaviour-influence. "Youth" (15-24) is a broad target group, but one where the impact could be greatly felt with strengthened and consistent targeted prevention efforts. Poor children in both the rural and urban areas, including street children, unaffiliated youth, children of PLWHA, and children with disabilities, would all be included in new or expanded programmes. Similarly, gender specific interventions will focus on "men," as a target group, with a special focus on gender-specific prevention programmes. Men in Jamaica are the primary "decision-makers" in negotiating sex and condom use, and it is proposed that by targeting them specifically, both men and women will benefit from this targeted intervention.

Policy-related intervention programmes will aim at supporting strategic interventions to reduce stigma and discrimination against people infected with or affected by HIV/AIDS. The strategic interventions will address the repeal of discriminatory laws and policies that make it difficult to reach vulnerable high-risk communities (especially MSM, CSWs, and incarcerated populations). Such policy efforts are largely aimed at protecting those who are either infected or most marginalised by Jamaican society.

**21.3. Greater reliance on domestic resources: describe in both narrative and quantitative terms how over the duration of the proposal the activities described will be increasingly financed using domestic resources, including the changes in the percentage of the budget covered by domestic vs. Global Fund resources (2–3 paragraphs)**

The thrust of this proposal is providing ARV treatment to those children and adults who need it but can not afford it. The JCCMHAR and Government of Jamaica recognise that sustainable ARV treatment programmes cannot depend forever on Global Fund resources. The strategic plans under development will include provisions for a gradual shift of financing of this essential therapy to local resources that will include government general revenues, social insurance coverage, private sector involvement, and out of pocket payments by those who can afford to pay.

**22. National context**

**22.1. Indicate the percentage of the total government budget allocated to health (optional for NGO applicants):  
4.22% of GDP are invested in health (2002-2003).**

**22.2. Indicate national health spending for 2001, or latest year available, in the Table III.22.2 (optional for NGO applicants):**

Table III.22.2

	<b>Total national health spending</b> Specify year: (USD) (in 1,000s) 2002-2003	<b>Spending per capita</b> (USD)
<b>Public</b>	158,481.51	60.95
<b>Private</b>	178,714.49	68.74
<b>Total</b>	337,196.00	129.70
<b>From total, how much is from external donors?</b>	2,871.42	1.10

**22.3. Specify in Table III.22.3, if possible, earmarked expenditures for HIV/AIDS, TB and/or Malaria (expenditures from the health, education, social services and other relevant sectors):**

Table III.22.3

<b>Total earmarked expenditures from government, external donors, etc.</b> Specify Year:	<b>In US dollars:</b>
<b>HIV/AIDS</b>	15,871,443
<b>Tuberculosis</b>	N/A
<b>Malaria</b>	N/A
<b>Total</b>	15,871,443

*\*NB= Amount includes expenditures in the health services, no expenditure programme yet established in line ministries*

**22.4. Does the country benefit from external budget support, Highly Indebted Poor Countries (HIPC) initiatives, Sector-Wide Approaches? If yes, how are these processes contributing to efforts against HIV/AIDS, TB and/or malaria? (1–2 paragraphs) (optional for NGO applicants):**

No.

**22.5. Describe the current national capacity (state of systems and services) that exist in response to HIV/AIDS, TB and/or Malaria (e.g., level of human resources available, health and other relevant infrastructure, types of interventions provided, mechanisms to channel funds, existence of social funds, etc.) (2–3 paragraphs):**

Jamaica has a well-developed public health system of affordable and accessible health care facilities throughout the country. There is, however, a shortage of doctors, nurses and other personnel (doctor to population ratio is 1:250 [citation]). However, many health care professionals are not adequately trained in HIV/AIDS care and treatment. In addition, there is a need to improve the structural maintenance of facilities, upgrade equipment, and secure adequate supplies of medicines and materials for treatment for these facilities. Some of these gaps have been addressed by the World Bank loan to Jamaica, so the improvements noted here are on-going. A major portion of the World Bank loan (US\$ 4.82 million or 29% of World Bank Project) is being devoted to strengthening the national capacity for an intensified response to the epidemic, specifically in training professionals and non-professionals, voluntary counselling and testing, prevention of mother to child transmission, additional staff, capacity building for NGOs, and structural improvements.

The national STI/HIV/AIDS Programme was established in 1986 with funding from the Government of Jamaica and USAID. Since then, Jamaica has been actively improving the technical, managerial, and implementation capacity of the key players within and outside the health sector; in the government, as well as in civil society, to address the epidemic. Activities include enhancing the planning, management, and implementation capacity of the National Programme at the regional and parish levels, strengthening the role of the National AIDS Committee (NAC), the role of other line ministries of

government, the private and voluntary sectors, and civil society. In addition the strengthened national response includes the development of HIV/AIDS work programmes for regional health authorities, an elevation of the NAC to a working group of the National Planning Council on HIV/AIDS, strengthened Parish AIDS Associations, technical assistance for the formulation of HIV/AIDS work plans in relevant line ministries, and capacity building for NGOs and CBOs through training and workshops

Part of an adequate response involves improving the information base for better decision-making. To that end, the GOJ/World Bank project supports the strengthening of the HIV/AIDS/STI surveillance system. This is being achieved by developing a surveillance plan and designing and implementing second-generation surveillance (i.e., with an emphasis on behavioural surveillance) for HIV/AIDS. This surveillance system is expected to pay special attention to vulnerable high-risk groups (MSM, CSWs). The surveillance system will be equipped with an integrated data management system for National Public Health Laboratories, hospital laboratories, STI and ANC clinics, sentinel surveillance sites, and hospital pharmacies, and by increasing Jamaica's capacity for operational research and dissemination of best practices in priority areas of the National Strategic Plan for HIV/AIDS (2002-2006). The implementation of the surveillance system, with its emphasis on behavioural surveillance, is a key feature of the project. It will provide invaluable information to inform the project's prevention activities.

**22.6. Name the main national and international agencies involved in national responses to HIV/AIDS, TB and/or Malaria and their main programmes (NGO applicants should specify partner organisations):**

Table III. 22.6

<b>Name of Agency</b>	<b>Type of Agency (e.g., Government, NGO, private, bilateral, multilateral, etc.)</b>	<b>Main programs (for example, comprehensive HIV/AIDS prevention; DOTS expansion over 3 years, etc.)</b>	<b>Budget (Specify time period) 2002</b>
United States Agency for International Development (USAID)	Bilateral	Support of the National HIV /AIDS/STI Control Programme, Ministry of Health	US\$ 1 million
United Nations Integrated Theme Group for HIV/AIDS	Multilateral	Advocacy, agency collaboration	US\$100,000
Pan American Health Organisation (PAHO)	Multilateral	Strengthening HIV/AIDS prevention/care programmes, e.g. PMTCT; accelerating access to antiretrovirals; programme support for strategic planning	US\$50,000
United Nations Children's Fund (UNICEF)	Multilateral	Support to prevention initiatives, increasing access of information to young people (e.g. Artistes Against AIDS, Youth Information Centres, Health & Family Education in schools); support to the pilot and expansion of PMTCT programme and support to the development of a National Plan of Action for orphans and other children made vulnerable by HIV/AIDS	US\$360,000
United Nations Development Program (UNDP)	Multilateral	Support capacity building; awareness efforts; sector planning; leadership initiatives; and policy development as it relates to HIV/AIDS	N/A

United Nations Educational, Scientific and Cultural Organisation (UNESCO)	Multilateral	HIV/AIDS prevention programmes, namely through education and curriculum development	N/A
United Nations Population Fund (UNFPA)	Multilateral	HIV/AIDS education and advocacy and condom procurement	US\$188,000
Canadian High Commission/Canadian International Development Agency (CIDA)	Bilateral	Enhanced support for HIV/AIDS within the Caribbean	N/A
Japan Embassy	Bilateral	Support for technical assistance	US\$475,000
Inter-American Development Bank (IDB)	Bilateral	Assistance in technical and capacity building for HIV/AIDS programmes	US\$150,000
Centre for HIV/AIDS Research, Education and Services	Government	Care and support for PLWHA; education and outreach work on HIV/AIDS; home based care training	US\$147,000
Jamaica AIDS Support	Non-governmental organisation	Care and support for PLWHA; targeted interventions with hard to reach communities; prison project; income generation project for PLWHA; education; HIV/AIDS training	US\$4100,000
The Jamaica Red Cross	National NGO with international affiliation	Care and support for PLWHA; targeted interventions with vulnerable high-risk groups (MSM, CSWs, incarcerated populations) education and principally youth peer programmes; home based care initiatives; education and HIV/AIDS training	US\$260,000 (Jan-Dec. 2002)
The National AIDS Committee	Non-governmental organisation	Advocacy; co-ordination of HIV/AIDS activities in member organisations	US\$67,000
University of the West Indies (UWI) HIV/AIDS Response Programme (HARP)	Academic institution	Training; research; education; curriculum development	US\$150,000
Germany/GTZ	Bilateral (phased out support, The Project will close Jamaican operations in 2003)	Strengthen the institutional response to HIV/AIDS, parish-level strengthening through the support of the Behaviour Change Communication Programme; targeted interventions with commercial sex workers	US\$250,000
United Kingdom (DFID)	Bilateral	HIV/AIDS education and advocacy	US\$9,000
World Bank	Multilateral	Care and Treatment, infrastructure upgrading, professional development, VCT training, etc.	US\$2 million

**22.7 What is the total budget required for the different diseases, list the sources and amounts available and needed including amount requested from the Global Fund.**

*Table III. 22.7*

Source/Agency	Amount In US dollars (millions):
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	2000	2001	2002	2003	2004	2005	2006
<b>HIV/AIDS</b>							
World Bank			0.04	3.15	5.44	3.64	3.16
USAID			1.00	1.00	1.00	1.00	1.00
UNICEF			0.18	0.18	0	0	0
GTZ			0.5	0.15	0	0	0
Government of Jamaica			0.86	2.24	3.22	3.32	3.32
Global Fund request			0	3.93	2.40	2.75	3.92
Unmet need			2.58	0.35	0.94	4.29	3.6
Total need			5.16	11	13	15	15
<b>Tuberculosis</b>							
Global Fund request							
Unmet need							
Total need							
<b>Malaria</b>							
Global Fund request							
Unmet need							
Total need							

**22.8. Describe the major programmatic intervention gaps and funding gaps that exist in the country's current response to HIV/AIDS, TB and/or Malaria (2-3 Paragraphs)**

The Government of Jamaica responded quickly to the HIV/AIDS epidemic, establishing a comprehensive National HIV/AIDS/STI Programme (NAP), housed in the Ministry of Health, in the late 1980s. In 1988, a multi-sectoral National AIDS Committee (NAC) was established to advise the MOH on policy issues and mobilise different sectors in the response. Jamaica's current response to the HIV/AIDS epidemic is making progress in several programmatic areas. As a result of extensive behaviour change communication campaigns, knowledge of means to prevent HIV infection is extremely high among adults (96%), and condom use with non-regular partners has increased substantially (from 37% of women in 1992 to 67% in 2000) (KABP Survey 2000). Thanks to universal antenatal screening and a system of contact investigation, rates of syphilis have declined precipitously, from 90 per 100,000 in 1987 to 10 per 100,000 in 2000. Nonetheless, the national response has gaps in key areas. The Jamaica HIV/AIDS/STI National Strategic Plan 2002-2006, which has been approved by Cabinet, and subsequently by Parliament, outlines five goals, which reflect these gaps:

- To build an effective multi-sectoral response to the HIV/AIDS epidemic;
- To mitigate the socio-economic and health impact of HIV/AIDS in the society;
- To decrease individual vulnerability to HIV infection;
- To reduce the transmission of new HIV infection; and
- To improve care, support and treatment services for people living with HIV/AIDS (PLWHA)

Of these goals, the biggest gap exists in the effort to improve care, support and treatment for PLWHA. Under the World Bank loan, efforts are under way to improve basic medical care, including the management of opportunistic infections, for PLWHA. Some funds from the World Bank loan, as well as USAID and CDC funding, are available to train

physicians and other health care providers in the management of HIV infection, training relative to ARV treatment. Recent negotiations have reduced the price of antiretroviral drugs, but the price remains too high to enable provision of antiretrovirals in the public sector. At present, an estimated 300 PLWHA in Jamaica are accessing antiretrovirals through the private sector. The Ministry of Health estimates 2,500 PLWHA (children and adults) will need at least partially subsidised ARV treatment by 2008. As patients are beginning to access antiretrovirals, adherence becomes a big issue. There is no structure in the country yet to deal with adherence and its associated issues.

An additional gap that has been identified is the “disconnect” between the high level of knowledge and stagnant behaviour change. While awareness of HIV/AIDS is nearly universal among Jamaicans, a significant minority of the population continues to put themselves and their partners at risk of HIV infection through unprotected sex with casual partners. This proposal will address this “residual risk” through targeted interventions focused on those most at risk of HIV infection and transmission: men who have sex with men (MSM), sex workers of both sexes, inner city and rural youth, the poor, and the mentally and physically disabled – and the partners of all these individuals. Efforts will also focus on secondary prevention, working with PLWHA to promote behaviour change among this important population. A third gap that has been identified is in the area of policy, advocacy and legislation. At present, people living with and affected by HIV/AIDS suffer high levels of stigma and discrimination, but do not have sufficient legal protection. This proposal will address gaps in policy, advocacy, and legislation through a variety of activities.

**22.9. If a SWAp or a similar fund pooling mechanism exists in your country, briefly describe how it is functioning and if you anticipate using it to administer the Global Fund grant**

NA

## SECTIONS IV – VIII: Detailed information on each component of the proposal

**PLEASE COMPLETE THE FOLLOWING SECTIONS FOR EACH COMPONENT**  
**Please copy sections IV – VIII as many times as there are components**

*Please note: a component refers to a disease, so the proposal will have more than one component only if it covers more than one disease. There should only be 1 component per disease.*

**If there are any objectives or broad activities within a particular component that are of a system-wide/cross-cutting nature such as capacity building or infrastructure development that may go beyond the scope of that particular component, please indicate those aspects clearly and specify how they would relate to other components of the proposal when detailing them in Question 26.**

*If this is a fully integrated proposal, where two or more components are linked in such a way which would not make it realistic or feasible to separate, mark the boxes in Table IV.23 to identify all diseases which would be directly affected by this integrated component.*

### **SECTION IV – Scope of proposal**

**23. Identify the component that is detailed in this section (mark with X):**

Table IV.23

<b>Component</b> (mark with X):	<input checked="" type="checkbox"/>	<b>HIV/AIDS</b>
	<input type="checkbox"/>	<b>Tuberculosis</b>
	<input type="checkbox"/>	<b>Malaria</b>
	<input type="checkbox"/>	<b>HIV/TB</b>

**24. Provide a brief summary of the component** (Specify the rationale, goal, objectives, activities, expected results, how these activities will be implemented and partners involved) (2–3 paragraphs):

The overall goal of the Jamaican proposal is to accelerate access to care for people living with HIV/AIDS, prevent the spread of HIV infection, protect the rights of people infected with or affected by HIV/AIDS, and generally, reduce the socio-economic and health impact of HIV on Jamaican society. Despite impressive gains in the fight against HIV/AIDS, the epidemic in Jamaica continues to be generalised, and thus HIV/AIDS remains a serious threat to the health and development of the Jamaican people. Seroprevalence rates are extremely high among vulnerable populations, including men who have sex with men (MSM) (20%) and commercial sex workers (CSWs) of both sexes (25%), and case fatality rates are intolerable. The proposal development process included an experience-based assessment of the status of implementation of the National Strategic Plan, with a view to the existing gaps in the national response. The proposal is designed to address these gaps. (Please see reports of stakeholder meetings, attachment GD5)

According to key stakeholders in the fight against HIV/AIDS, including PLWHA, the National HIV/AIDS/STI Programme (NAP), National AIDS Committee (NAC), and key NGOs, the lack of access to antiretroviral treatment is the biggest gap in the national response. At present, antiretroviral drugs are only available in the private sector, at a cost that is out of reach of the majority of Jamaicans. This proposal will accelerate access to antiretroviral therapy, diagnostic services, and psychosocial support in the public sector. This support aspect should assist in adherence. Key partners for the implementation of

activities include the Ministry of Health, the National Public Health Laboratory, the University of the West Indies, and the VCT Programme.

The proposal will also scale up existing activities in two other areas: prevention and policy. Prevention activities will focus on those groups most vulnerable to HIV infection: MSM, CSWs, youth, the poor, and the mentally and physically disabled. Behaviour change communication efforts will also target men from the general population, since it is often their behaviour that drives the epidemic. Thus, women – who are often powerless to make safer sex decisions – are another major target. Implementing agencies for prevention activities will include NGOs and groups representing PLWHA, Parish AIDS Committees, the private sector, organisations representing both employers and employees, and the NAP. Policy and advocacy activities will focus on improving the protection of human rights and reducing stigma and discrimination against persons living with and affected by HIV/AIDS. Activities will include policy development, advocacy, and public education. Key partners for policy and advocacy activities include line ministries, including Health, Education, Labour, Tourism, and National Security; private sector organisations; the Jamaica Employers Federation; the Jamaica Confederation of Trade Unions; Council of Voluntary Social Services; and UN agencies, notably, UNDP.

**25. Indicate the estimated duration of the component:**

Table IV.25

<b>From</b> (month/year):	1/2004	<b>To</b> (month/year):	12/2008
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**26. Detailed description of the component for its FULL LIFE-CYCLE:**

*Please note: Each component should have ONE overall goal, which should translate into a series of specific objectives. In turn each specific objective should be broken-down into a set of broad activities necessary to achieve the specific objectives. While the activities should not be too detailed they should be sufficiently descriptive to understand how you aim to achieve your stated objectives.*

**Indicators:** *In addition to a brief narrative, for each level of expected result tied to the goal, objectives and activities, you will need to identify a set of indicators to measure expected result. Where applicable this set of indicators should include the core indicators as listed in Annex A.*

**Baseline data:** *Baseline data should be given in absolute numbers and percentage. If baseline data is not available, please refer to Guidelines. Baseline data should be from the latest year available, and the source must be specified.*

**Targets:** *Clear targets should be provided in absolute numbers and percentage.*

**26.1. Goal and expected impact** (Describe overall goal of component and what impact, if applicable, is expected on the targeted populations, the burden of disease, etc.) (1–2 paragraphs):

*Please note: the impact may be linked to broader national-level programmes within which this component falls. If that is the case, please ensure the impact indicators reflect the overall national programme and not just this component.*

*Please specify in Table IV.26.1 the baseline data. Targets to measure impact are only required for the end of the full award period.*

Table IV.26.1

<b>Goal:</b>	Strengthening the multi-sector national response to prevent and address the HIV/AIDS epidemic in Jamaica	
<b>Impact indicators</b>	<b>Baseline</b>	<b>Target (last year of proposal)</b>
	<b>Year: 2003</b>	<b>Year: 2008</b>
Percentage of HIV-infected infants born to HIV-infected mothers	<b>30% estimated</b>	<15%
HIV seroprevalence among 15-24 age group	<b>1.2% (based on ANC)</b>	<1%

**26.2. Objectives and expected outcomes** (Describe the specific objectives and expected outcomes that will contribute to realizing the stated goal) (1 paragraph per specific objective):

*Question 26.2 must be answered for each objective separately. Please copy Question 26.2 as many times as there are objectives.*

*Please note: the outcomes may be linked to broader programmes within which this component falls. If that is the case, please ensure the outcome/coverage indicators reflect the overall national programme and not just this component.*

*Specify in Table IV.26.2 the baseline data to measure outcome/coverage indicators. Targets are only required for Year 2 onwards.*

**Objective 1: To improve availability and quality of monitoring and diagnostic services for PLWHA of all ages**

(Please see attachment GD6 for background on treatment and care issues and practices) Laboratory capacity for monitoring and diagnosis will be improved to provide dependable screening, confirmation, and monitoring tests for patients with HIV/AIDS, including both children and adults. The central, Kingston-based National Public Health Laboratory's (NPHL) capacity to identify indicators of progression of infection/immune impairment will be significantly improved by including the following equipment: 2 CD4 machines, 2 viral load machines, and 2 PCR testing machines. The Government of Jamaica/World Bank funding will provide infrastructural adjustments to the laboratory to house this equipment. Currently, CD4 counts are inconsistently available from the University Hospital of the West Indies, and at a great cost to the patient. Viral load testing can only be accessed abroad, again, at high costs. Attention will also be paid to the capability of the laboratory to assess the accuracy and reproducibility of results, supporting the development of individual plans of action for on-going quality assessment and improvement. The introduction of decentralised rapid HIV testing and the expansion of the VCT programme by the Government of Jamaica in the wider national HIV/AIDS response will significantly reduce the burden on the NPHL, allowing this entity to focus on key laboratory support, as noted above.

**Expected outcomes:**

- Baseline CD4 cell counts available for monitoring of HIV-positive individuals
- Patients started on ARV therapy will be monitored using CD4 counts twice yearly; and viral load testing according to standardised treatment guidelines.
- HIV-positive infants of affected mothers will be diagnosed between 6 weeks and 6 months, using PCR testing, according to national guidelines on Prevention of mother to child transmission.

- Decentralised testing will allow for more of the population to be screened; island-wide access to VCT, particularly for pregnant women; and will allow the central lab to focus on quality control.

Table IV.26.2

<b>Objective: 1</b>	<b>To improve availability and quality of monitoring and diagnostic services for PLWHA of all ages</b>				
<b>Outcome/coverage indicators</b>	<b>Baseline</b>	<b>Targets</b>			
	<b>Year: 2003</b>	<b>Year 2: 2005</b>	<b>Year 3: 2006</b>	<b>Year 4: 2007</b>	<b>Year 5: 2008</b>
No. of individuals (children and adults) receiving CD4 levels in the public sector, in accordance with guidelines	0	1700	2000	2500	3000
No. of infants born to HIV+ mothers receiving PCR testing according to national standards within the first 6 months	0	400	600	800	1000
No. of individuals (children and adults) on ARV therapy receiving viral load testing, in accordance with guidelines	0	1200	1500	2000	2500
No. of individuals tested for HIV (including pregnant women), in accordance with guidelines	25,000	70,000	110,000	150,000	200,000

### **Objective 2: Island-wide provision of adherence counselling and psychological support**

In the public health sector, a significant gap exists in human resource capacity to deliver psychological support, long term counselling, and, particularly, to provide interventions to promote adherence to antiretroviral therapy. Over 250 individuals have been trained under the Government of Jamaica/World Bank/USAID VCT Programme (in the context of the wider national HIV/AIDS response) to provide voluntary pre- and post-test counselling at the time of HIV testing. A trained cadre of staff is now needed to support the expansion of these services to provide adherence counselling when appropriate. A programme will be developed to supplement agencies already providing training in counselling and counselling psychology. Some of the institutions currently doing such training include: the University of the West Indies, the Caribbean Graduate School of Theology, University of Technology, Mico College, and Youth Empowerment Officers (YEOs) from the National Centre for Youth Development (NCYD). Health care workers who have been trained in VCT will also receive additional counselling and adherence training, according to their level within the health service. Adherence promotion interventions will utilise the existing group of pharmacists who, at this point, provide limited counselling and support services. Training for PLWHA, NGOs, FBOs, CBOs, and individuals from target populations will also augment this process.

#### **Expected outcomes:**

- Adherence counselling programmes integrated into existing training programmes for professional counsellors.
- Development of structured adherence programmes at all treatment centres.
- Expansion of VCT programmes to include on-going counselling in adherence and provision of emotional support.
- Development of support groups in each Parish across the island, led by specially trained PLWHA and community volunteers, in association with existing NGOs (e.g. PACs, JAS, JN+)

<b>Objective: 2</b>	Island-wide provision of adherence counselling and psychological support				
<b>Outcome/coverage indicators</b>	<b>Baseline</b>	<b>Targets</b>			
	<b>Year: 2003</b>	<b>Year 2: 2005</b>	<b>Year 3: 2006</b>	<b>Year 4: 2007</b>	<b>Year 5: 2008</b>
No. of trained counsellors, including community volunteers, providing adherence counselling and psychological support	0	100	150	200	250
No. of PLWHA trained in counselling and psychological support	0	50	100	150	200
No. of health care workers trained in counselling and psychological support	0	100	150	200	250
No. of regional treatment centres with adherence counselling provided by trained staff	0	3	4	4	4
No. of adherence support groups started by NGO/PAC partnerships using trained PLWHA	0	6	8	10	12

### **Objective 3: Provide antiretroviral therapy to PLWHA of all ages**

At present, antiretroviral therapy is accessible only in the private sector. Although there is a consistent supply of all the major drugs, this is usually at great cost, making it difficult for patients to adhere to prescribed treatment regimes. Additional difficulties arise when physicians lack training in the use of ARV therapy. Other problems have arisen due to patients seeking to access medication from abroad without the appropriate medical follow-up and potential interruptions in access. They also seek to acquire medication on the black market, leading to drugs being taken before they are indicated or in inadequate dosages. Medical management guidelines are currently being developed, and continuing medical education of physicians and other health care workers to manage appropriate combination schemes is being implemented in Jamaica, supported through IDB/UNICEF/USAID and World Bank Loan funding. Regional treatment centres are also being developed with the assistance of the World Bank and USAID, thus establishing the mechanism through which efficient and appropriate services can be delivered to PLWHA. To ensure sustainability, the public access programme for ARV will include the following: ARVs at cost for those who can afford them (delivered through existing government mechanisms to ensure minimal or no mark up of products); subsidised for some who can only afford to pay a part of the cost; and free to a limited number of people who cannot afford them and who meet a set criteria, to be established by the National HIV/AIDS Programme. All drugs will be purchased via the existing government mechanisms and made available through the existing public health facilities and the newly developed treatment centres, ensuring the minimal cost to those who utilise these services. This logistic system will ensure ongoing availability of antiretroviral drugs with limited continued subsidy required from the government's recurrent budget. This activity is supported by the improvement of the monitoring capacity of the laboratory services (objective 1), and will also be complemented by counselling programmes to promote and evaluate adherence (objective 2). Through the World Bank loan, an amount of money is also available for demand-driven sub-projects. Some of these may be income-generating projects, which will aid PLWHA in purchasing medication, and thus assist in ensuring sustainability.

#### **Expected outcomes:**

- Antiretroviral therapy available to PLWHA, both children and adults, who meet the set criteria for commencing ARVs. At least 15% will be children under the age of 15.

- Adequate monitoring systems and psychological support in place for patients on ARV therapy to promote adherence.
- Decreased AIDS case fatality rate from 60% to below 25% among those receiving appropriate ARV therapy.
- Improved quality of life of PLWHA.

Table IV.26.2

<b>Objective: 3</b>	<b>Provide antiretroviral therapy to PLWHA of all ages</b>				
<b>Outcome/coverage indicators</b>	<b>Baseline</b>	<b>Targets</b>			
	<b>Year: 2003</b>	<b>Year 2: 2005</b>	<b>Year 3: 2006</b>	<b>Year 4: 2007</b>	<b>Year 5: 2008</b>
No. of individuals (adults and children) with AIDS receiving effective combination ARV therapy, according to national guidelines	0	600	1200	2000	2500

**Objective 4: To increase safer sex practices and improve attitudes and behaviours among vulnerable high-risk groups.**

Jamaica has an HIV infection rate of 1-1.5%. While treatment is paramount, there is still a need to concentrate on – and scale up – prevention efforts. Initiatives to reduce transmission must be expanded and strengthened in both the general population and in selected vulnerable high-risk groups. This specific objective is aimed at increasing safer sex practices and improving attitudes and behaviours within vulnerable high-risk groups. Prevention programmes need to be intensified in those populations that are most at risk of being infected or of transmitting HIV, primarily CSWs (10%-20% prevalence in high prevalence areas) and MSM (25% prevalence). These groups (and their sexual partners), and persons living with HIV/AIDS (PLWHA) (and their sexual partners), will be targeted in this objective. There are several factors that make these groups especially vulnerable and also make them difficult to reach. These factors include: commercial sex work is illegal in Jamaica, widespread homophobia drives homosexuals/bisexuals underground, stigma and discrimination towards marginalised groups, including PLWHA, inhibit their willingness to access health services and prevention information.

**Expected outcomes:**

- CSWs reporting consistent condom use with each client/partner
- MSM reporting consistent condom-use with each partner
- Established VCT programme for CSWs and MSM
- PLWHA reporting consistent condom-use

<b>Objective: 4</b>	<b>To increase safer sex practices and improve attitudes and behaviours among vulnerable high-risk groups.</b>				
<b>Outcome/coverage indicators</b>	<b>Baseline</b>	<b>Targets</b>			
	<b>Year:</b>	<b>Year 2:</b>	<b>Year 3:</b>	<b>Year 4:</b>	<b>Year 5:</b>
The proportion of CSWs who report condom use with last client	75%	NA	NA	NA	85%
Percentage of MSM and their partners who used a condom during last anal sex	25% (Estimate – to be adjusted based on July 2003 baseline)	30%	35%	38%	40%
New HIV infections among discordant partners (in a sample of accessible persons living with HIV)	0%	NA	<5%	NA	<10%

**Objective #5: To delay sexual initiation, promote abstinence, and increase condom use among sexually active young people.**

This specific objective is intended to delay sexual initiation, promote abstinence, and increase condom use among sexually active adolescents and young people. Research conducted in a 2000 Knowledge, Attitudes, Behaviours, and Practices (KABP) survey indicated that the mean age of sexual debut remained at 13 for boys and 14 for girls, as the proportion of 15-19 year olds who are sexually active increased. Girls 15-19 years are particularly vulnerable because of involvement in transactional and coercive relationships with older men, among other factors. Prevention programmes targeted to adolescents and young people need to be expanded to effectively promote abstinence as a viable option, and consistent condom use for those who are sexually active. Adolescents and young people need to better understand their sexuality in order to heighten their individual sense of risk and be better able to make informed sexual choices. As part of the general population, this target group is bombarded by conflicting sexual messages through the media and popular culture, pointing to the need to train and sustain advocates in the popular culture and media sectors to promote messages of abstinence and condom use. Although students are targeted with HIV prevention education through the formal system, implementation is inconsistent and difficult to monitor and evaluate. While steps are being taken to strengthen the existing curriculum on Health and Family Life Education (HFLE), additional efforts must be taken to ensure that subject delivery can be monitored and evaluated. There is a need to develop and incorporate HIV/AIDS prevention education programmes in correctional service institutions, and expand targeted community interventions for adolescents and young people who are out of school. Children in care institutions, adolescents and young people in both the inner city and in deep rural communities are particularly at risk, with little or no co-ordinated access to HIV prevention education or condoms (male or female). It is also imperative that user-friendly environments for adolescents and young people be established and sustained to promote sexually healthy lifestyles among them. Participation by this target group should be increased at all levels of HIV prevention intervention, and peer education and counselling intervention sustained in community-based organisations (CBOs) and in faith-based organisations (FBOs).

**Expected outcomes:**

- Delayed age of sexual initiation.
- Increased abstinence.
- Increased condom use.
- Increased access to condoms/health services.
- Increased appropriate risk perception.

<b>Objective: 5</b>	<b>To delay sexual initiation, promote abstinence, and increase condom use among sexually active young people</b>				
<b>Outcome/coverage indicators</b>	<b>Baseline</b>	<b>Targets</b>			
	<b>Year:</b>	<b>Year 2:</b>	<b>Year 3:</b>	<b>Year 4:</b>	<b>Year 5:</b>
Median age at first sex increases at least by 0.5 year	13 (boys) 14 (girls)	NA	NA	NA	13.5 (boys) 14.5 (girls)
The percentage of young people aged 15 to 24 reporting the use of a condom during sexual intercourse	61% (male) 47% (female)	NA	NA	NA	80% (males) 70% (females)
The percentage of young people aged 15 to 19 reporting no sexual activity in the last year	24.2% (boys) 45.7% (girls)	NA	NA	NA	34% (boys) 50% (girls)
Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.	65% male 78% female	NA	NA	NA	90% (male and female)

**Objective #6: To increase safer sexual practices and improve attitudes and behaviour in the general population, including persons with disabilities. Men will be a special target of this objective.**

To reduce transmission of HIV, there is a need to increase safer sexual practices and improve attitudes and behaviour in the general population, including persons with disabilities. A major factor influencing recurring risk behaviours, despite high prevention knowledge, is deep-rooted socio-cultural mores that give adult men in heterosexual unions the right to make the sexual decisions. Multiple partnerships are generally accepted, despite knowledge of the associated risk, and this practice has contributed to fragmented family structures with limited male involvement in parenting. The media and popular culture also promote gender inequality and risky sexual behaviours. Other barriers to behaviour change include poverty, violence, unemployment, denial of risk, cultural and religious taboos, stigma and discrimination, substance abuse, and a resurgence of incorrect beliefs. The KAPB survey of 2000 indicated that 24% of adult men and 33% of adult women reported no condom-use with non-regular partners. In recognising the need to empower women to negotiate condom use, it is critical to target the sexual decision-makers (male adults) in unions to increase the practice of consistent and correct condom use. Promotion of Voluntary Counselling and Testing (VCT) is also crucial, as there is a correlation between knowledge of HIV status and reduction in risk behaviour. Specific interventions have never been developed to target persons with disabilities. Owing to the generalised nature of the epidemic, however, there is a need to include this vulnerable and hitherto neglected group as a consideration when materials and interventions are being developed.

**Expected outcomes:**

- 85% use of condom at last sex with a non-regular partner.
- Reduction in partners/increased mutual monogamy.
- Improved understanding of sexuality.
- Increased number of condom sale outlets.
- Increased appropriate risk assessment.
- Increased HIV/STI prevention knowledge among persons with disabilities.

<b>Objective: 6</b>	<b>To increase safer sexual practices and improve attitudes and behaviour in the general population, including persons with disabilities. Men will be a special target of this objective.</b>				
<b>Outcome/coverage indicators</b>	<b>Baseline</b>	<b>Targets</b>			
	<b>Year:</b>	<b>Year 2:</b>	<b>Year 3:</b>	<b>Year 4:</b>	<b>Year 5:</b>
The proportion of men/women aged 15-49 years who report using a condom in their last sexual intercourse with their non-regular partner	76% (men) 66% (women)	NA	82% (men) 72% (women)	NA	85% (men)  76% (women)
The proportion of men/women aged 15-49 who report having sex with more than one partner in the last 12 months	54% (men)  15% (women)	NA	47% (men)  15% (women)	NA	40% (men)   15% (women)

**Objective 7: To improve the protection of the rights of persons living with or affected by HIV/AIDS by developing a comprehensive policy framework.**

Although Jamaica's National Strategic Plan (2002-2006), adopted unanimously by Parliament in June 2002, calls for a clear policy and legislative framework on HIV/AIDS, progress in attaining these objectives has been slow. The JCCMHAR believes it is necessary to establish a legislative framework in which laws, policies and government practices come together to protect the rights of those most vulnerable to HIV/AIDS, as well as those living with and affected by HIV/AIDS. Currently, there is no specific AIDS legislation and a review conducted in 2001 by the National AIDS Committee identified a number of areas where weaknesses exist within present legislation. In particular, it pointed to a need for the repeal of discriminatory legislation relating to buggery, commercial sex work, obscenity, vagrancy, age of consent, access to services for minors, and acceptable health. As a consequence of these legislative weaknesses, vulnerable and marginalised groups, such as CSWs, MSM, the incarcerated populations, and, youth, are inadequately protected, and others are often discriminated against. The problem is compounded by the high level of stigma associated with AIDS, the homophobia that permeates the society, and the cultural sensitivity of these issues in the Jamaican society. Jamaican law is currently silent on such areas as pre-employment HIV testing and termination of employment based on HIV status. There is also no framework in which such things as reported cases of schools discriminating against children infected with or affected by HIV/AIDS can be addressed. Although efforts have begun to develop policies in line ministries, workplaces, and the nation, as a whole, it is clear that much more needs to be done, and urgently. At present, there is an impending reform of the Occupational Health and Safety Act. In addition, the ministries of Tourism and Education have started to develop sector policies on HIV/AIDS, and the development of a national HIV/AIDS policy has begun. Objective 7, therefore, seeks to affirm and protect the rights of people living with or affected by HIV/AIDS and to provide a caring, protective, and supportive social environment for such persons. The process will focus on the completion of the National Policy to provide an overall framework to guide the national response, including the provision of assistance to complete sector and workplace policies. It will also include the execution of advocacy campaigns to bring attention and advance changes to the legislative framework. The advocacy campaign will primarily target senior members of the political directorate, as well as public and private sector officials. This overall objective will be executed using a highly consultative process involving national and localised discussions of the policy and legislative issues.

**Expected outcomes:**

- A supportive, caring, and protective social environment for those affected by the disease.
- Advancement of the legislative agenda for greater protection of the rights of PLWHA, MSM, CSWs, and youth.

- Implementation of a comprehensive National HIV/AIDS Policy, and sector-specific and workplace policies.

<b>Objective: 7</b>	<b>To improve the protection of the rights of person living with or affected by HIV/AIDS by developing a comprehensive policy framework.</b>				
<b>Outcome/coverage indicators</b>	<b>Baseline</b>	<b>Targets</b>			
	<b>Year: 2003</b>	<b>Year 2: 2005</b>	<b>Year 3: 2006</b>	<b>Year 4: 2007</b>	<b>Year 5: 2008</b>
Approved national Policy on HIV/AIDS	Draft Policy	Green Paper	Under consideration for approval by Parliament	Approval by Parliament	Used as a standard for government decision making
Number of large (more than 100 employees) private organisations adopting and implementing appropriate policies addressing HIV/AIDS	40	60	70	80	90
Number of government ministries adopting and implementing appropriate policies addressing HIV/AIDS	2	5	8	12	15
Number of educational institutions adopting and implementing appropriate policies addressing HIV/AIDS	40	50	60	70	90
Number of large (more than 100 employees) private organisations not requiring pre employment HIV testing.	<b>40</b>	60	70	80	90

**Objective 8: To reduce stigma and discrimination against persons living with and affected by HIV/AIDS through advocacy and public education.**

Jamaica has had a historically high level of stigma and discrimination against PLWHA and those affected by the disease. In the last few years there have been cases of children with HIV/AIDS being turned away from schools as a result of their HIV/AIDS status or their association with PLWHA. Many workplaces also have terminated the employment of PLWHA and continue to conduct HIV pre-employment testing. Stigma and discrimination also extend to high-risk groups, such as MSM and CSWs, whose fundamental human rights are often abused. The implementation of programmes to address these strong social issues will hinge on an increased level of political will and commitment of senior policy makers, as well as key public, private sector, and civil society organisations and individuals. The advocacy and public education objective is, therefore, firstly targeted at getting senior members of the government and private sector leaders to publicly prioritise the development and implementation of HIV/AIDS policies (by means of a signed document of support for advocacy efforts), and to increase the allocation of resources for HIV/AIDS programmes. The objective is geared at developing and executing a multi-media campaign that addresses stigma towards individuals infected with or affected by HIV/AIDS, MSM, and CSWs. The objective also seeks to strengthen and build on the present advocacy initiatives as they relate to PLWHA, MSM, and CSWs, ensuring that these target groups are given a voice, with the ultimate aim being to reduce their vulnerability and protect their constitutional rights. The objective also seeks to implement reporting and control mechanisms to galvanise and more effectively co-ordinate the multi-sectoral response to the epidemic.

## Expected outcomes

- General population with greater accepting attitudes towards PLWHA.
- Increased allocation and prioritisation of resources for HIV/AIDS programmes by government.
- Private, public, government officials publicly signing a document of support and discussing the need for anti-discriminatory policies to protect the rights of vulnerable high-risk groups.
- Improved institutional mechanisms for co-ordination and reporting of HIV/AIDS related discriminatory practices.

<b>Objective: 8</b>	<b>To reduce stigma and discrimination against persons living with and affected by HIV/AIDS through advocacy and public education.</b>				
Outcome/coverage indicators	Baseline	Targets			
	Year: 2003	Year 2: 2005	Year 3: 2006	Year 4: 2007	Year 5: 2008
Number of large (more than 100 employees) private organisations not discriminating against employees with or affected by HIV	40	60	70	80	90
Number of reported cases of discrimination in educational institutions	20	15	10	5	3
Number of reported cases of discrimination in health care settings	5	10	15	20	25
Proportion of population with accepting attitudes towards persons living with or affected by HIV/AIDS	30%	35%	40%	45%	50%
Reported number of cases of discrimination against PLWHA	5	10	15	20	25

### 26.3. Broad activities related to each specific objective and expected output

(Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

*Please note: Process/output indicators for the broad activities should directly reflect the specified broad activities of THIS component.*

*Specify in Table IV.26.3 below the baseline data to measure process/output indicators. Targets need to be specified for the first two years of the component.*

*For each broad activity, specify in Table IV.26.3 who the implementing agency or agencies will be.*

#### **Broad activities related to Objective 1: To improve availability and quality monitoring and diagnostic services for PLWHA of all ages**

- Viral load/PCR testing: Procure two pieces of equipment (one to be used in the central lab and one in the Western Region, and each serving as backup for the other) for viral load/PCR testing, with required reagents, service contracts, and maintenance programmes.

- CD4 testing: Procure two pieces of equipment (one to be used in the central lab and one in the Western Region, and each serving as backup for the other) for evaluating CD4 levels, with required reagents, service contracts, and maintenance programmes
- Training of adequate numbers of lab staff to operate equipment efficiently.

Table IV.26.3

<b>Objective: 1</b>	<b>To improve availability and quality monitoring and diagnostic services for PLWHA of all ages</b>				
<b>Main activities</b>	<b>Process/Output indicators</b> (indicate one per activity; refer to Annex A)	<b>Baseline</b>	<b>Targets</b>		<b>Responsible/Implementing agency or agencies</b>
		<b>(Specify year) 2003</b>	<b>Year 1 2004</b>	<b>Year 2 2005</b>	
Procure two CD4 counting machines and reagents	Equipment procured and installed	NA	Equipment procured and installed	Reagents available at NPHL for required no. of tests	MOH/National Public Health Laboratory
Training of staff	8 staff members trained and working	0	4 staff members trained	4 staff members trained	MOH/National Public Health Laboratory
Procure viral load/PCR testing equipment and reagents	Equipment procured and installed	NA	Equipment procured and installed	Reagents available at NPHL for required no. of tests	MOH/National Public Health Laboratory

**Broad activities related to Objective 2: Island-wide provision of adherence counselling and psychological support for PLWA**

- HIV counselling component to be developed for integration into existing counselling programmes.
- Development of expanded VCT programme to include psychological support and adherence counselling.
- Adaptation of existing basic counselling skills course for community volunteers and PLWHA.
- Development of a structured adherence programme at treatment centres.
- Training of different categories of health care workers in adherence counselling and on-going psycho-social support.
- Training of community volunteers and PLWHA, and strengthening of PLWHA support groups to assist in self-care and adherence.

<b>Objective: 2</b>	<b>Island-wide provision of adherence counselling and psychological support for PLWHA</b>				
<b>Main activities</b>	<b>Process/Output indicators</b> (indicate one per activity; refer to Annex A)	<b>Baseline</b>	<b>Targets</b>		<b>Responsible/Implementing agency or agencies</b>
		<b>(Specify year) 2003</b>	<b>Year 1 2004</b>	<b>Year 2 2005</b>	
HIV counselling component developed for integration into existing counselling programmes	Percentage of counselling programmes with adequate HIV component	25%	50%	75%	UWI
Development of adherence programme	No. of Treatment centres with structured adherence programme	0	2	3	Ministry of Health/NAP
Train cadre of professional staff in adherence counselling and ongoing psychological support	No. of HCWs trained	20	50	100	Ministry of Health/NAP
Train cadre of community volunteers	No. of community volunteers trained to provide adherence counselling and psychosocial support	10	50	100	JAS NAC
Train cadre of PLWHA	No. of PLWHA trained in adherence counselling and psychological support	5	25	50	JN+
	No. of support groups	4	6	10	

**Broad activities related to objective 3: Provide antiretroviral therapy to PLWHA of all ages**

- Procure and distribute antiretroviral therapy according to needs of patients of all ages, and consistent with national guidelines.

<b>Objective: 3</b>	<b>Provide antiretroviral therapy to PLWHA of all ages</b>
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Main activities	Process/Output indicators (indicate one per activity; refer to Annex A)	Baseline	Targets		Responsible/ implementing agency or agencies
		(Specify year) 2003	Year 1 2004	Year 2 2005	
Procure and distribute ARV therapy	Number of children and adults on ARV therapy	50	300	600	Ministry of Health/ Health Corporation Ltd

**Broad activities related to Objective 4: To increase safer sex practices and improve attitudes and behaviours among vulnerable high-risk groups.**

- **Establish non-traditional condom outlets for vulnerable groups – CSW, MSM, the poor, youth, the disabled, PLWHA, etc.** This will involve accessing condom dispensing machines and liaising with commercial and public sector distributors of condoms and ensuring that new and existing informal networks have access to condoms. Special attention will be paid to making condoms accessible to the poor and people with disabilities.
- **Increase access to VCT by vulnerable groups.** Development of VCT programmes for vulnerable groups, using peer counsellors whenever possible.
- **Sustain CSW and MSM peer education programmes.** This will involve recruiting and training CSWs and MSM to reach their peers with safer sex messages, including use of female and male condoms, and teaching condom negotiation skills.
- **Develop targeted approaches for CSWs and for MSM, utilising new and existing informal networks.** This will involve recruitment of Behaviour Change Communication Co-ordinators to work with CSWs and MSM peer educators in designing, implementing, and evaluating interventions targeted to male and female CSWs and MSM, assessing consistent condom use, and encouraging and providing VCT.
- **Design and implement secondary prevention intervention programmes for PLWHA.** This will include producing and printing low literacy and audio/visual material and distributing condoms. Programmes will use peer counsellors to encourage status disclosure by PLWHA to their sex partners, increase condom use among sexually active PLWHA, offer guidelines for proper care and nutrition, and provide emotional support.

<b>Objective 4: To increase safer sex practices and improve attitudes and behaviours among vulnerable at risk groups.</b>					
<b>Main activities</b>	<b>Process/Output indicators</b> (indicate one per activity; refer to Annex A)	<b>Baseline</b>	<b>Targets</b>		<b>Responsible/Implementing agency or agencies</b>
		<b>2003</b>	<b>Year 1</b>	<b>Year 2</b>	
Establish non-traditional condom outlets for vulnerable groups	Number of non-tradition outlets established	2500	2600	2750	NAC
Disseminate information on VCT and site-access	Percentage of surveyed MSM and CSWs reporting knowledge of VCT and access sites	0	25%	50%	MOH/VCT Programme
Sustain peer education programmes for CSWs and MSM	Number of functioning peer education programmes	1	5	8	JAS
Develop targeted approaches for CSWs and MSM	Number and type of approaches	7	12	14	JAS
Recruit peer educators to design, implement and evaluate targeted approaches	Number of persons recruited	0	4 (CSWs) 3 (MSM)	4 (CSWs) 3 (MSM)	JAS
Design and implement secondary prevention intervention programme for PLWHA.	Intervention designed and implemented	0	1	1	JN+ CHARES
Produce printed and audio/visual material	Number/type material produced	0	Set of 4 brochures (5000 copies)	1 15-min video	MOH/NAP

Distribute male and female condoms and lubricants	Number of condoms/lubricants distributed	10	10,000	10,000	MOH/NAP
Train peer counsellors	Number of peer counsellors trained	15	15 (support group members)	15 (support group members)	JN+
Support for NGO strengthening	Number of NGOs	0	24	24	NAC

**Broad activities related to Objective 5: To delay sexual initiation, promote abstinence, and increase condom use among sexually active young people**

- **Develop monitoring and evaluation tool for delivery of HFLE and relevant secondary and tertiary level courses.** This task will include revision of existing curricula related to HIV and development of new curricula utilising methods that can be monitored and evaluated.
- **Prepare and reproduce curriculum material for classrooms** (pre-primary, primary, secondary and tertiary). This task will include the production/printing of curriculum material, text and workbooks, production of audio-visual material and CDs.
- **Develop and implement interventions using cultural approaches to promote delayed sex and consistent condom use among vulnerable adolescents and young people** (street boys, inner city/rural young people). Interventions will include the participation of adolescents and young people at all levels of development and implementation.
- **Using existing NGOs/CBOs, promote and support user-friendly and gender-sensitive services targeted to adolescents and young people.** Interventions will be based on findings, studies, protocols and standards that ensure that young people will have access to healthy lifestyle services and education without barriers. Outputs will include training of advocates and the creation of user-friendly spaces at new and existing sites and settings.
- **Promote and sustain existing young people’s hotline.** Outputs include training young people as counsellors, expanding the telephone facilities, promoting the hotline through small media, and recruiting a part-time administrator.
- **Develop mass media campaign to promote delayed sex, abstinence, and condom-use for sexually active young people.** Outputs include television and radio 30-second spots, print and outdoor advertising and promotional novelties. A message recall survey will be conducted.

<b>Objective 5:</b>	<b>To delay sexual initiation, promote abstinence, and increase condom use among sexually active young people</b>
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Main activities	Process/Output  indicators (indicate one per activity; refer to Annex A)	Baseline	Targets		Responsible/ Implementing agency or agencies
		2003	Year 1	Year 2	
Develop monitoring and evaluation tool for delivery of HFLE and relevant tertiary level courses	Tools developed	0	Drafts developed and reviewed	Tools implemented	UWI-HARP, Hope Worldwide
Produce and print curriculum material for classroom	Number printed	0	500,000	250,000	Ministry of Education
Develop and implement interventions using cultural approaches to promote delayed sex, abstinence, and consistent condom use among vulnerable adolescents and young people (street boys, inner city/rural young people etc)	Number and type of group reached using cultural approaches	0	12 groups	18 groups	Jamaica Red Cross
Promote and support young people-friendly and gender-sensitive services through existing young people-focused NGOs/CBOs.	Number of NGOs/CBOs providing young people-friendly services	4	8	10	MOH/NAP
Promote and sustain young people hotline	Number of calls to hotline	200 per month	300 per month	400 per month	Jamaica Foundation for Children

Develop mass media campaign to promote delayed sex, abstinence, and condom use among sexually active young people	Campaign developed and placed: television, radio, print, outdoor advertising, promotional novelties	One campaign on delayed sex and condom use	One campaign on delayed sex and condom use developed and placed	Continued placement of campaign material	MOH/ Youth.now,
Conduct message recall surveys	Number/type of messages recalled	0	1 Message recall survey conducted	Message recall survey conducted	MOH/Youth .now

**Broad activities related to Objective 6: To increase safer sexual practices and improve attitudes and behaviour in the general population, including persons with disabilities. Men will be a special target of this objective.**

- **Build capacity of CBOs and FBOs to conduct interventions by training key stakeholders.** Over the two-year period, outputs include 250 key stakeholders from 15 CBOs and 450 key stakeholders from major church associations trained in HIV prevention education. Special emphasis will be on reaching men, so sports and service groups will be targeted within these organisations.
- **Develop and implement mass media campaign to promote voluntary counselling and testing. Conduct message recall survey.** Outputs include one campaign on voluntary counselling and testing produced and placed, using television, radio and print advertisements, and billboard and bus panel messages; and a message recall survey.
- **Develop, produce and distribute culturally appropriate tools, including low literacy materials and materials for the physically and mentally challenged.** These materials will cover delaying sex, abstinence, consistent condom use, voluntary counselling and testing, risk assessment, condom negotiation, male sexuality and other topics.
- **Procure, strategically place, and distribute condom dispensing machines, and penis and vagina models.** This will include procurement and distribution of 80 dispensing machines, 400 penis models and 400 vagina models over a two-year period.
- **Train 30 trainers for the physically and mentally challenged to impart HIV/AIDS prevention information.** Peer trainers will be used wherever possible.

<b>Objective 6:</b>	<b>To increase safer sexual practices and improve attitudes and behaviour in the general population, including persons with disabilities. Men will be a special target of this objective.</b>
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Main activities	Process/Output indicators (indicate one per activity; refer to Annex A)	Baseline	Targets		Responsible Implementing agency or agencies
		2003	Year 3	Year 4	
Train key stakeholders in CBOs	Number of persons trained	0	100	150	Jamaica Red Cross
Train key stakeholders in FBOs	Number of persons trained	60	100	350	Jamaica Council of Churches,
Develop and distribute culturally appropriate materials	Number of materials produced: Examples of materials includes: Low literacy VCT brochure	0	500,000	750,000	MOH/NAP
	Video on condom use and negotiation skills	0	200	200	
	Video on male sexuality	0	200	200	
	Risk assessment flier	0	500,000	500,000	
	Low literacy basic facts on HIV/AIDS brochure	0	500,000	500,000	
Develop mass media campaign to promote voluntary counselling and testing	Campaign developed and placed over 6 month period per year: television, radio, print, outdoor advertising (billboards, bus panels etc.)	0	1 campaign developed and placed	1 campaign placed	MOH/VCT
Conduct message recall survey	Messages recalled		1 survey conducted	1 survey conducted	MOH/NAP
Procure and place condom dispensing machines	Number of machines procured and placed	12	30	50	MOH/NAP
Procure and distribute penis models	Number of penis models procured and distributed	144	200	200	MOH/NAP
Procure vagina models	Number of vagina models procured and distributed	0	200	200	MOH/NAP

Train trainers for physically and mentally challenged to impart HIV/AIDS prevention information	Number of trainers trained	5	20	10	3D
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**Broad Activities related to Objective 7: To improve the protection of the rights of persons living with or affected by HIV/AIDS by developing a comprehensive policy framework.**

- **Completion of a National HIV/AIDS Policy**

This process will entail facilitating national public consultations on the development of the National HIV Policy and lobbying campaigns targeted at the political directorate to gain political commitment to policy implementation and legislative changes. There will also be targeted consultations and meetings with senior public and private sector officials, community based organisations, civil society, line ministries of government and special interest groups, such as PLWHA, MSM, persons with disabilities, CSWs, and employers. The activities will also include submission of the Policy document to Cabinet for approval by Parliament. On completion of the Policy, brochures and other informational material will be produced and disseminated. This will form part of a sustained media campaign to increase public awareness of the Policy.

- **Establish mechanism to capture reports of discrimination against PLWHA and those affected by HIV/AIDS.**

This activity includes building on and strengthening the institutional capacity of organisations to record cases of discrimination .A centralised monitoring and evaluation system will be instituted at JN+. A media campaign will be undertaken to inform the public of the existence of these facilities and to provide information on reporting discrimination, persons constitutional rights, and mechanisms of redress.

- **Programme to assist with the development and implementation of operational and workplace policies.**

The Ministry of Health, in partnership with relevant agencies, will provide technical assistance to public and private sector workplaces in the development of organisational policies relevant to HIV/AIDS. A series of workshops and consultations will be held to sensitise and orient employers and employees to the need for and content of such policies. A Toolkit will be developed and disseminated throughout the various sectors to act as a framework/guide for organisational policy development. There also will be training workshops focused on developing, operationalising, and monitoring the policies.

<b>Objective: 7</b>	<b>To improve the protection of the rights of person living with or affected by HIV/AIDS by developing a comprehensive national Policy framework</b>				
<b>Main activities</b>	<b>Process/Output</b>	<b>Baseline</b>	<b>Targets</b>		<b>Responsible /Implementing agency or agencies</b>
	<b>indicators</b> (indicate one per activity; refer to Annex A)	<b>(Specify year)</b>	<b>Year 1</b>	<b>Year 2</b>	
Complete the National HIV/AIDS Policy	Policy approved/ passed by Parliament	Preliminary draft policy completed	Conduct 5 stakeholder consultations to provide input  prepare green paper	Complete policy and get approval by Parliament	PIOJ
Technical assistance given to large (more than 100 employees) organisations (including unions) on workplace policies	No. companies given materials and consultations	0	Toolkit on workplace policy developed  Work with 2 companies	Work with 10 companies	NAC
Large (more than 100 employees) private organisations implementing workplace policies on HIV/AIDS	# of workplaces that have actively implemented an acceptable HIV/AIDS policy	Meetings and consultations on operationalisation process	40% of large (more than 100 employees) organisations with active workplace policies	65% of organisations with active workplace policies	PSOJ
Technical assistance to government ministries to develop and implement policies relative to HIV/AIDS	All government ministries and their agencies to develop and implement policies	Preliminary meetings held with 5 ministries	3 additional ministries and their agencies to have workplace policies	5 additional ministries to have workplace policies	NAC

**Broad activities related to Objective 8: To reduce stigma and discrimination against persons living with and affected by HIV/AIDS through advocacy and public education.**

- **Public education and sensitisation campaign**

The programme will involve a general public education and sensitisation campaign, which will include mass media campaigns. Also to be included will be seminars and workshops with stakeholders (NGOs, CBOs, FBOs, etc), newsletters and brochures, internet

information, and community and national radio, aimed at sensitisation to improve knowledge and awareness of policies and reduce stigma and discrimination against PLWHA, MSM, CSWs, and others. Major events (concerts, marathons etc.) will be staged and televised to coincide with World AIDS Day and other significant calendar events. Competitions and fairs aimed at school children will be held. A special television and radio broadcast of a sitting of Parliament, focusing on HIV/AIDS, is one of the targeted activities. Activities and techniques will attempt to reach the people who are the most directly affected by discrimination, including PLWHA, MSM, CSWs, people with disabilities, and the poor. An aspect of this will be helping PLWHA and their families develop support groups, which can play a major role in their own advocacy.

- **Establish a network of advocates**

This activity seeks to first identify a key group of advocates, comprising PLWHA and non-PLWHA, drawn from private, public, non-profit, faith-based, media, and community-based entities. Led by an advocacy expert or lobbyist, this group will formulate and implement advocacy strategies that will target bridge populations (MSM, CSWs, bi-sexual men, persons with STIs, etc), decision makers from the political and private sectors, informal community leaders, and international partners. The second stage of the activity will entail a series of island-wide meetings and consultations, hosted by the partnership group, with the various stakeholders. There will also be visits from similar groups from other countries to share their experiences with the local partnership group, and vice-versa. The issues of importance to those affected by HIV/AIDS will be championed.

- **Advocacy campaign targeting political leaders, senior government officials, and the legal fraternity.**

Under this activity, a series of study tours will be organised for members of the political directorate, public and private sector, and the legal fraternity. These tours will be aimed at educating these leaders on best practices relating to human rights and advocacy for PLWHA and those affected by the disease. There will also be visits from prominent international figures/personalities to meet with political leaders and other members of civil society. This exchange of ideas, processes, methods of operation, etc. is expected to strengthen Jamaica's HIV/AIDS response, add creativity, and establish international networks that can continue to provide benefits far into the future.

<b>Objective: 8</b>	<b>To reduce stigma and discrimination against persons living with and affected by HIV/AIDS through advocacy and public education.</b>				
<b>Main activities</b>	<b>Process/Output indicators</b> (indicate one per activity; refer to Annex A)	<b>Baseline</b>	<b>Targets</b>		<b>Responsible/Implementing agency or agencies</b>
		<b>(Specify year)</b>	<b>Year 1</b>	<b>Year 2</b>	
Advocacy campaign targeting increased participation by political leaders	Political consensus achieved on policy and legislative agenda and greater prioritisation of HIV programmes and spending	Government now spends \$4.5 million on HIV/AIDS programmes; Ministers of Health and Development frequently speak on HIV/AIDS issues	Develop document of support  5 consultations with high level political leaders  Document of support signed off by political leaders	5 consultations with senior civil servants  Implementation of 40% of issues listed in document of support	PIOJ
Advocacy campaign targeting decision makers in the public/private sector and civil society	Multi-sector consensus on impact issues	Breakfast meetings held and multi-sector partnerships formed	5 consultations with private sector leaders  Document of support signed off by all	Implementation of 50% of document of support issues	PSOJ JEF
Public education and sensitisation campaign to improve knowledge of laws/policies and reduce stigma and discrimination against PLWHA, MSM, CSWs, and others	Reduction in stigma and discrimination.  Increased awareness of policy/legislative issues affecting HIV/AIDS	New media campaign on stigma and discrimination	Education -al material on laws and policies developed and disseminated	Stage national schools debating competition on HIV/AIDS issues. Produce and air full documentary on HIV/AIDS	MOH/NAP

Study tour by Political Leaders to learn from the experiences of other countries in fighting stigma and discrimination and developing effective HIV/AIDS strategies/ programmes	Number of tours	NA	1 study tour by political leaders to other countries	NA	NAC
Advocacy campaign targeting members of the judiciary and legal fraternity on key legislative and policy issues	Number of participants	0	Visits by 2 leading international experts on HIV/AIDS legislation 2 seminars with members of legal fraternity	Visits by 2 leading international experts on HIV/AIDS legislation 2 seminars with members of the legal fraternity	NAC
PLWHA directly involved in fighting discrimination	No. of PLWHA support groups strengthen	3	6	10	JN+
Establish mechanism to capture reports of discrimination against those affected by or infected with HIV/AIDS	Number of reports	0	Database created	Establish regional points of contact through the PACs	UWI-HARP

Establish advocacy group to co-ordinate matters relating to advocacy	Group created	0	Form advocacy group consisting of PLWHA and non-PLWHA  Special broadcast of parliamentary session on HIV/AIDS	Recruit advocates from affected populations, general public, leaders	JN+
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- 27. Describe how the component adds to or complements activities already undertaken by the government, external donors, the private sector or other relevant partner:** (e.g., does the component build on or scale-up existing programs; does the component aim to fill existing gaps in national programs; does the proposal fit within the National Plan; is there a clear link between the component and broader development policies and programmes such as Poverty Reduction Strategies or Sector-Wide Approaches, etc.) (2–3 paragraphs):

(Please see background information for more detail, attachment GD6.) Using the National Strategic Plan on HIV/AIDS (2002-2006) as the foundation for all HIV/AIDS programmes in the country, the activities funded under the Global Fund grant would complement and scale up efforts already under way through the Ministry of Health, the National AIDS Committee, the Regional Health Authorities, the United Nations Theme Group, Parish AIDS Committees, non-governmental, community-based and faith-based organisations, and private sector operations currently undertaking HIV/AIDS activities. At the beginning of the Global Fund proposal process, care was taken to meet with representatives of all these sectors to determine their assessment of gaps that need to be filled. There was remarkable agreement on where the gaps exist: provision of antiretroviral drug treatment for PLWHA, adherence, prevention efforts aimed at high-risk groups; and policy issues, including continuing to pursue development of an overall HIV/AIDS policy for the country and legislation that protects PLWHA and removes obstacles to reaching certain high-risk groups. (Please see attachment GD5, report on stakeholder meetings.)

These meetings also provided an opportunity for stakeholders to identify crosscutting issues that may or may not have been seen in the past to be essential areas of consideration. Programmes and projects under the Global Fund will incorporate these crosscutting issues, including gender issues, consideration for people with disabilities, the impact on stigma and discrimination against PLWHA, and the need to develop more baseline data.

Jamaica has had a comprehensive HIV/AIDS response programme in place since 1988. Much has been accomplished since then, with the most recent efforts focusing on upgrading the medical infrastructure, training health practitioners in the complexities of HIV/AIDS, initiating development of an overall national policy relative to HIV/AIDS, conducting practical research on the socio-economic impact of the epidemic, developing a national strategy (led by the Ministry of Health and signed on-to by other line ministries), managing a comprehensive programme to prevent mother to child transmission, reducing the costs of antiretrovirals, training large numbers of people in VCT, and more. These programmes have effectively slowed the epidemic in the country, raised awareness of the disease, provided a safe blood supply, and had other positive effects, but work is still needed to manage and limit the disease in Jamaica, especially in high-risk populations, including those already infected. The grant provided by the Global Fund will be applied, in part, to overall monitoring and evaluation of all expenditures in the fight against HIV/AIDS in Jamaica. The JCCMHAR and its research,

monitoring, and evaluation support groups will maintain records, both for its own application of Global Fund monies and for all resources (public, private, and donor originating), that contribute to prevention and care for this disease. The JCCMHAR will provide regular reporting on a transparent basis to the people of Jamaica, to those most directly affected by HIV/AIDS, and to the organisations that provide ongoing technical and financial support for these efforts.

**28. Describe innovative aspects to the component: (1–2 paragraphs)**

Innovative aspects of this component include the involvement of PLWHA in the design and implementation of both prevention activities and care and treatment activities, particularly those that relate to secondary prevention and counselling for adherence to antiretroviral medications. Activities to reach the physically and mentally disabled are also innovative, as these groups have not benefited from targeted prevention interventions to date.

Two other innovative aspects for Jamaica are:

- Prevention programmes targeting men as a means to actually protect women;
- Training non-professionals, including PLWHA and community volunteers in adherence and on-going psycho-social counselling for PLWHA.

**29. Briefly describe how the component addresses the following issues (1 paragraph per item):**

**29.1. The involvement of beneficiaries such as people living with HIV/AIDS:**

Because of the focus on care and antiretroviral treatment, PLWHA are the main beneficiaries of the component. PLWHA have been involved since the beginning of the proposal development process; they have a key role in the NAC and the JCCMHAR. Representatives of PLWHA, such as members of the Jamaica Network of Seropositives (JN+), were involved in the design, writing and review of this proposal, and will be involved in the implementation of the project, both as an implementing agency for some activities and as a partner in others.

**29.2. Community participation:**

Community organisations, including the Parish AIDS Committees (PACs), faith-based organisations (FBOs), and NGOs, all play key roles in the national response to HIV/AIDS in Jamaica. The PACs have a close working relationship with the NAC and are actively implementing activities in all 14 parishes in the country. While the PACs are not listed as implementing agencies, they will be vital in programme development, implementation, monitoring and evaluation. A large percentage of Jamaicans are members of a church, and these resources need to be more fully tapped in the national response. Finally, Jamaica is home to a variety of NGOs, some of which focus exclusively on HIV/AIDS and others that are able to reach important target populations (for example, MSM and the physically and mentally disabled). These NGOs are key partners in the national response and will be important as the JCCMHAR develops and implements programmes under this proposal.

**29.3. Gender equality issues:**

Gender roles play an important part in the HIV/AIDS epidemic in Jamaica. Women and girls, especially poor women and girls, often lack the ability to control when and with whom they have sex, and may not always be able to negotiate condom use with their partners. Due to machismo, Jamaican society not only tolerates, but also encourages, young men and boys to have many female sexual partners, placing young men and boys and their female partners at risk of infection. At the same time, intense discrimination and stigma against homosexuality drives men who have sex with men (MSM) underground, often keeping a heterosexual lifestyle for public view, and a secret homosexual life. This not only impedes efforts to implement prevention activities among this important population, but also results in infections among unsuspecting female partners. Poverty and unemployment exacerbate gender equality

issues, increasing the number of women, men and children of both sexes who engage in transactional sex. One significant aspect of this proposal targets men in the general population. The intention is to address these issues and encourage men to recognise their responsibilities relative to their own sexual health and that of their partner (s). Groups representing women's issues, MSM issues, and other gender equality issues have been involved from the inception of the proposal and will be part of the implementation and monitoring teams.

#### **29.4. Social equality issues:**

Jamaica is a lower-middle income country (as categorised by the World Bank). However, poverty, violence, and unemployment constitute major social problems in Jamaica. HIV infection rates are highest in the most urbanised parishes, St. James (home of Montego Bay) and Kingston/St. Andrew. Poverty is strongly correlated with risky behaviours, notably transactional sex. At present, poverty impedes the access of PLWHA to antiretroviral therapy, which has not been available in the public sector, while wealthy Jamaicans are able to access these drugs in the private sector. This proposal will remedy this gross inequity by setting up a means testing system in the public sector, enabling poor Jamaicans to access life-saving therapy while ensuring that those with the ability to pay continue to access antiretroviral drugs through the private sector.

#### **29.5. Human Resources development:**

In order to promote sustainability, it is essential that the activities outlined in this proposal work towards increasing the capacity of human resources at the national, regional and parish levels. Activities contemplated in each objective, in addition to reaching beneficiary populations, will focus on the transfer of knowledge and skills to healthcare providers, programme managers, staff at NGOs and FBOs, as well as to PLWHA themselves, and peer educators in target populations. Programmes funded by the government of Jamaica, the World Bank and others have a more direct focus on human resource development, so this was not seen as a gap of the same magnitude as those covered more specifically in this proposal.

## **SECTION V – Budget information**

### **30. Indicate the summary of the financial resources requested from the Global Fund by year and budget category**

Table V.30

Resources needed (USD)	Year 1	Year 2	Year 3 (Estimate)	Year 4 (Estimate)	Year 5 (Estimate)	Total
Human Resources	910,650	731,550	444,150	49,750	17,600	<b>2,153,700</b>
Infrastructure/Equipment	650,000	-	18,000	30,000	-	<b>698,000</b>
Training/Planning	1,118,970	717,934	797,060	556,650	51,200	<b>3,241,814</b>
Commodities/Products	186,300	176,000	240,000	307,000	355,000	<b>1,264,300</b>
Drugs	644,297	1,288,595	2,577,190	4,252,363	5,373,441	<b>14,135,887</b>
Monitoring and Evaluation	74,585	80,520	164,520	6,400	66,400	<b>392,425</b>
Administrative Costs	120,150	149,800	99,600	90,000	-	<b>459,550</b>
Other (Please specify)	340,382	370,632	208,532	26,800	26,800	<b>973,146</b>
<b>Total</b>	<b>4,045,334</b>	<b>3,515,031</b>	<b>4,549,052</b>	<b>5,318,963</b>	<b>5,890,441</b>	<b>23,318,822</b>

***The budget categories may include the following items:***

***Human Resources:*** Consultants, recruitment, salaries, etc.

***Infrastructure/Equipment:*** Building infrastructure, cars, microscopes, etc.

***Training/Planning:*** Training, workshops, meetings, etc.

***Commodities/Products:*** Bednets, condoms, syringes, educational material, etc.

***Drugs:*** ARVs, drugs for opportunistic infections, TB drugs, anti-malaria drugs, etc.

***Monitoring & Evaluation:*** Data collection, analysis, reporting, etc.

***Administrative:*** Overhead, costs for Principal Recipients associated with managing the project, audit costs, etc

***Other (please specify):***

**31. For drugs and commodities/products, specify in the table below the use of the commodity, unit costs, volumes and total costs, for the FIRST YEAR ONLY:**

Please indicate the International Non-proprietary Name of the medicines, rather than the brand names.

Please indicate what the commodity/drug will be used for (e.g., whether antiretrovirals are for prevention of mother-to-child transmission or adult treatment; whether insecticides are used for net treatment, retreatment or indoor residual spraying).

Unit prices for pharmaceutical products should be the **lowest** of: prices currently available locally; public offers from manufacturers; or price information for public information sources.<sup>‡</sup> If prices from sources other than those specified above are used, a rationale must be included.

<sup>‡</sup> Sources and Prices of Selected Drugs and Diagnostics for People Living With HIV/AIDS. Copenhagen/Geneva, UNAIDS/UNICEF/WHO-HTP/MSF, 3<sup>rd</sup> edition, May 2002 (<http://www.who.int/medicines/library/par/hivrelateddocs/prices-eng.pdf>); Market News Service, Application Form for Proposals to the Global Fund

Volumes indicated in the table below should be consistent with activity targets specified in section 26 when these activities involve procurement.

The Total Cost of Drugs and Commodities/Products should equal the sum of the Commodities/Products and Drugs lines for Year 1 in the table above.

**Total Cost of Drugs: Year 1 Table V.31**

Item/unit (using International Non-proprietary Names for pharmaceuticals)	Purpose	Unit cost (USD)	Volume (specify measure)	Total cost (USD)
Zidovudine + Lamivudine	Antiretroviral therapy for adult treatment.	\$0.70/ 300/150 mg tablet	182,500 tablets	127,750
Zidovudine	Antiretroviral therapy for adult treatment.	\$0.20/ 100 mg capsule	109,500 capsules	21,900
Zidovudine Oral Solution	Antiretroviral therapy for treatment.	\$5.5/ 100ml 50mg/5 ml	600 100ml bottles	3,300
Didanosine	Antiretroviral therapy for adult treatment.	\$0.39/ 200 mg tab.	73,000 tablets	28,470
Abacavir	Antiretroviral therapy for adult treatment.	\$3.69/ 300 mg tablet	28,370 tablets	104,685
Efavirenz	Antiretroviral therapy for adult treatment.	\$0.39/ 200 mg capsule	219,000 capsules	85,410
Nevirapine	Antiretroviral therapy for adult treatment.	\$0.56/ 200 mg tablet	73,000 tablets	40,880
Nelfinavir	Antiretroviral therapy for treatment.	\$1.22/ 250 mg capsule	172,131 capsules	209,999.5
Stavudine	Antiretroviral therapy for adult treatment.	\$0.25/ 40 mg capsule	18,250 capsules	4,562
Lamivudine	Antiretroviral therapy for adult treatment.	\$0.36/ 150 mg tablet	36,500 tablets	13,140
Lamivudine Oral Solution	Antiretroviral therapy for adult treatment.	\$7.00/ 100 ml 50 mg/5ml	600 100ml bottles	4,200
Sub-total drugs				644,297
Supplies for CD4 tests	Testing for and monitoring HIV progress	\$40.00	1000	40,000
Supplies for PCR tests	Testing for and monitoring HIV progress	\$60.00	200	12,000
Supplies for viral load tests	Testing for and monitoring HIV progress	\$70.00	500	35,000

Pharmaceutical starting materials and essential drugs, WTO/UNCTAD/International Trade Centre and WHO (<http://www.intracen.org/mns/pharma.html>); International Drug Price Indicator Guide on finished products of essential drugs, Management Sciences for Health in collaboration with WHO (published annually) (<http://www.msh.org>); First-line tuberculosis drugs, formulations and prices currently supplied/to be supplied by Global Drug Facility (<http://www.stoptb.org/GDF/drugsupply/drugs.available.html>)

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Maze panels	Educational material	\$15,000.00	6	90,000
Condom dispensing machines	Non-traditional condom outlets	\$600.00	3	1,800
Penis models	Condom use skill development	\$20.00	90	1,800
Vagina models	Condom use skill development	\$75.00	60	4,500
Lubricants	Risk reduction	\$0.12	10,000	1,200
Sub-total commodities				186,300
Total drugs & commodities				\$830,597

**31.1. Budget justification: Please indicate assumptions or formulas used to calculate volume of drug/commodity necessary to achieve coverage targets specified in section 26.**

The volume of drugs necessary to achieve coverage targets is based on the number of patients and the treatment regimes as outlined in the WHO Treatment Guidelines.

**31.2. In cases where Human Resources (HR) is an important share of the budget, explain to what extent HR spending will strengthen health systems capacity at the patient/target population level, and how these salaries will be sustained after the proposal period is over (1 paragraph):**

Human Resources is not a significant part of this proposal. The World Bank Loan funding is helping to address this need. Intensified and expanded training of health care workers, volunteers, PLWHA, and others is more of a focus for this proposal, as well as some limited human resource expansion for strengthening the capacities of NGOs, CBO, and FBOs.

**32. If you are receiving funding from other sources than the Global Fund for activities related to this component, indicate in the Table below overall funding received over the past three years as well as expected funding until 2005 in US dollars:**

*Table V.32*

	1999	2000	2001	2002	2003	2004	2005
<b>Domestic (public only)</b>	0.2	0.86	1.02	1.22	1.32	1.32	1.32
<b>External (millions)</b>	1.7	1.72	1.8	4.48	6.44	4.64	4.16
<b>Total (m)</b>	<b>1.9</b>	<b>2.58</b>	<b>2.82</b>	<b>7.7</b>	<b>9.67</b>	<b>5.96</b>	<b>5.48</b>

*Please note: The sum of yearly totals of Table V.32 from each component should correspond to the yearly total in Table 1.b of the Executive Summary. For example, if Year 1 in the proposal is 2003, the column in Table 1.b labelled Year 1 should have in the last row the total of funding from other sources for 2003 for all components of the proposal.*

**33. Provide a full and detailed budget as attachment, which should reflect the broad budget categories mentioned above as well as the component's activities. It should include unit costs and volumes, where appropriate.**

Please see attachment GD10.

**34. Indicate in the Table below how the requested resources will be allocated to the implementing partners, in percentage:**

Table V.34

Resource allocation to implementing partners* (%)	Year 1	Year 2	Year 3 (Estimate)	Year 4 (Estimate)	Year 5 (Estimate)	Total
Government	81%	77%	72%	87%	99%	70%
NGOs/ Community-Based Org.	10%	14%	21%	13%	1%	28%
Private Sector	0%	0%	0%	0%	0%	0%
People living with HIV/TB/ malaria	0%	0%	0%	0%	0%	0%
Academic/ Educational Organisations	7%	6%	5%	0%	0%	0%
Faith-based Organisations	0%	0%	0%	0%	0%	0%
Others (please specify)	2%	2%	2%	0%	0%	2%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Total in USD</b>	<b>1,045,334.79</b>	<b>3,515,031.00</b>	<b>4,549,052.00</b>	<b>5,318,963.50</b>	<b>5,890,441.15</b>	<b>23,318,822.4436</b>

- If there is only one partner, please explain why.

Please note that a detailed one year work plan and an indicative work plan for the second year need to be provided with detailed budget. See template in Annex B to this form.

***Please note: The following three sections (VI, VII and VIII) are all related to proposal/component implementation arrangements.***

***If these arrangements are the same for all components, you do not need to answer these questions for each component. If this is the case, please indicate clearly in which component the required information can be found.***

## **SECTION VI – Programmatic and Financial management information**

*Please note: Detailed description of programmatic and financial management and arrangements are outlined in Guidelines Para. VI. 67 – 74, including the main responsibilities and roles of the Principal Recipient (PR).*

### **35. Identify your Principal Recipient(s) (PR)**

*Table VI.35*

<b>Name of PR</b>	Project Co-ordination Unit	
<b>Name of contact</b>	Dr. Yitades Gebre, Executive Director	
<b>Address</b>	2-4 King Street Kingston, Jamaica	
<b>Telephone</b>	(876) 967-1100, ex. 2100	
<b>Fax</b>	(876) 967-1643	
<b>E-mail</b>	gebrey@moh.gov.jm	

*Please note: If you are suggesting having several Principal Recipients, please copy Table VI.35 below.*

**35.1. Briefly describe why you think this/these organisation(s) is/are best suited to undertake the role of a Principal Recipient for your proposal/component** (e.g. previous experience in similar functions, capacity and systems in place, existing contacts with sub recipients etc) (1–2 paragraphs)

The Project Co-ordination Unit (PCU) was established to facilitate the implementation of the Jamaica HIV/AIDS Prevention and Control Project with a complement of 4 technical officers, including the Executive Director and 5 administrative officers. The Unit was structured based on a multiple implementing agencies matrix, which includes NGOs, FBOs, line ministries and regional health authorities. This arrangement has been replicated in the Financial and Procurement Management systems of the PCU (Attached Operational Manual for PCU). These systems currently support a disbursement volume of approximately US\$1.5M per annum. The PCU is based in the Ministry of Health and is audited annually by private auditors (Mair Russell and Partners). The Government of Jamaica’s Auditor General’s Department conducts verification audits and the Unit is subject to the internal audit framework of the Ministry of Health. The PCU is governed by standard World Bank systems, procedures, and regulations and is, therefore, well suited for the assimilation of these protocols in the management and disbursement of additional resources. Additional human resources will be required to monitor the increased financial and administrative responsibilities of the PCU.

The PCU has established working relationships with most implementing agencies for HIV/AIDS in the island through its implementation arrangements with the National AIDS Committee and the National AIDS Programme. The PCU also supports the implementation of HIV/AIDS sub-projects by NGOs, FBOs and CBOs, and has gained administrative and technical experience in the management of resources in the context of community led HIV/AIDS response.

**35.2. Briefly describe how your suggested Principal Recipient(s) will relate to the CCM and to other implementing partners** (e.g., reporting back to the CCM, disbursing funds to sub-recipients, etc.) (1 paragraph)

The PCU will be the secretariat of the JCCMHAR. The Executive Director of the PCU will be a member of the JCCMHAR and will be responsible for reporting on the technical and administrative implementation of activities supported through the Global Fund. The JCCMHAR will convene quarterly to review the implementation programme and make recommendations for policy and programme changes. The JCCMHAR will further authorise the establishment of an Operational Management (OM) Sub-committee that will be chaired by the Executive Director of the PCU. This committee will convene monthly and will have responsibility for the overall management of Global Fund resources. The OM will also be responsible for the review of all technical and administrative matters related to implementation of the project, including the collation of reports to the JCCMHAR and the development of implementation work programmes. Implementing agencies will be required to open Global Fund project accounts to receive funds from the PCU. Funds disbursed to implementing agencies will be authorised by the Chair of the JCCMHAR and the Executive Director of the PCU and subject to the official audit arrangements of the PCU. Global Fund resources will be required to remain separate for appropriate financial management. A special account will be established by the UNDP to receive all funds related to the implementation of the Policy objectives of the proposal. This arrangement will be made in order to facilitate the role of the UNDP as the lead agency in the implementation of these activities. The UNDP will report directly to the JCCMHAR on issues related to the implementation of programme activities and will submit reports to the PCU with regards to the Financial and Procurement arrangements.

**36. Describe the proposed management arrangements** (outline proposal implementation arrangements, roles and responsibilities of different partners and their relations) (1–2 paragraphs)

The Project Co-ordination Unit (PCU), housed in the Ministry of Health, will be the gatekeeper for Global Fund monies. The PCU will disburse funds to implementing agencies, which will oversee projects in specified areas. The implementing agencies will receive disbursements on a quarterly basis, reporting on programme implementation and expenditures at the end of each quarter. The implementing agencies will delegate some activities to other agencies, organisations and individuals, but will retain responsibility for accounting for expenditures and the achievement of success, as spelled out in the monitoring and evaluation plans.

**36.1. Explain the rationale behind the proposed arrangements** (e.g., explain why you have opted for that particular management arrangement) (1 paragraph)

The PCU has proven its effectiveness in administering the World Bank/Government of Jamaica funds and has good working relationships with the implementing agencies. Many of its procedures can be extended to service the needs of the Global Fund projects. The implementing agencies have been chosen for their expressed interest in overseeing and participating in the given activities; proven capacity to manage resources; accepted position as a leader in the specific area; and their commitment to working with other agencies, community members, special target groups, etc.

**37. Briefly indicate links between the overall implementation arrangements described above and other existing arrangements** (including, for example, details on annual auditing and other related deadlines). **If required, indicate areas where you require additional resources from the Global Fund to strengthen managerial and implementation capacity** (1–2 paragraphs)

Please see explanation in # 35.2 above.

## **SECTION VII – Monitoring and evaluation information**

### **38. Outline the plan for conducting monitoring and evaluation including the following information (1 paragraph per sub-question).**

#### **38.1. Explain the overall approach to M&E**

The JCCMHAR's overall approach to monitoring and evaluation (M&E) is to include all stakeholders, respond to new needs and conditions as they arise, use all existing reliable data systems available to the extent possible, and to follow these steps:

1. In collaboration with all stakeholders and consistent with globally accepted indicators, identify all information essential to answer the following questions:
  - a. Is the intervention being implemented as planned?
  - b. Is the intervention having the desired effect?
2. Determine already existing reliable data sources that adequately reflect the identified essential information;
3. For those essential data when no existing data source exists, develop and implement procedures to capture data regularly;
4. Develop a feasible plan to collect, organize, monitor quality of and analyze all information routinely;
5. Develop regular mechanisms to provide data to all stakeholders and obtain feedback to adjust the programme and to adjust the M&E framework as appropriate.

To implement this approach we will use the same team approach utilised by the National HIV/AIDS/STI Programme and the same mechanism – the Monitoring and Evaluation Reference Group (MERG), which monitors and evaluates the progress in the national response to HIV/AIDS. The Monitoring and Evaluation Reference Group is a multi-sector group with representation from all the stakeholders (including line ministries, UN agencies, non-government agencies, PLWHA) addressed in the National HIV/AIDS response. The group meets quarterly to review M&E plans, provide adjustments to the system, and review and discuss current data. This group has taken into consideration M&E systems being utilized in the country (e.g. the Millennium Development Goals) and internationally. This ensures that the system in place is appropriate to assess and guide programme implementation and overall programme performance, as well as, overall health impact.

#### **38.2. Describe how the beneficiaries will be involved in M&E**

The intended beneficiaries of this programme will include the following:

- People living with HIV/AIDS (PLWHA), including HIV+ women and families
- Men having sex with men (MSM)
- Youth (including out of school, MSM and CSW)
- Commercial sex workers (CSW)
- Inner City residents and deep rural area residents
- Persons with disabilities
- Faith based and community base organizations
- Men

Beneficiaries will be involved in M&E in three ways. First, they will help to ensure that indicators reflecting beneficiaries' concerns are included in the M&E plan. Second, representatives of these groups, which include Jamaica AIDS Support, Jamaica Network of Seropositives, Youth.now, etc., will be involved with the assessment and evaluation of the project. They will do so by facilitating access to those they represent and obtaining

information to assess the effects of the programme. Facilitating access may be particularly helpful in this programme because some beneficiaries (e.g., MSM, CSW, PLWHA), due to legal and cultural views, may be unwilling to reveal themselves to those they may perceive to pose a threat.

**38.3. Describe how the CCM or other partners will be involved in M&E (e.g., oversight, data review, capacity building, quality control and validation of data).**

The Terms of Reference of the M&E Reference Group states that they report to, and obtain approval from, the JCCMHAR as the monitoring and reporting mechanism. The JCCMHAR and other partners will therefore be involved in M&E in two ways: data gathering and data utilisation. Regarding data gathering, the JCCMHAR, through the Monitoring and Evaluation Reference Group, will provide guidance and approval of the monitoring and evaluation plan to ensure the most useful and feasible data are collected. Throughout the programme, the JCCMHAR will suggest additional indicators as the programme or the epidemic changes. Regarding data use, the general objective of monitoring and evaluation ensures that the information system to support decision-making provides relevant data for monitoring the HIV/AIDS epidemic in Jamaica. The JCCMHAR, through the M&E Reference Group (of which several are members), will be commissioning assessment and evaluation reports. These organisations will further be informed of programme progress and effects via newsletters, quarterly reports, through the Monitoring and Evaluation Reference Group, and through various meetings with stakeholders. This will aid the JCCMHAR to observe timeliness, ensure funds are being utilised for the intended purpose, and obtain information on the appropriateness of the programme design and interventions.

**38.4. Describe what already exists. How does the existing health information system work and how it will be used to manage and/or report proposal data (e.g., Demographic Health Surveys, Living Standards Measurement Surveys)**

(Please see attachmentGD7, showing the existing system and the strategic framework)

Several relevant information systems already exist in Jamaica and function reliably. Others are in development. Characteristics of the systems are described in the following table.

Source	Data collected	Target group	Responsible	Periodicity
MIS Management Information Systems	Hospital Clinical Summary Report Monthly clinical Summary Report	All ages attending hospitals and clinics	MOH, RHA	Monthly
BBS Behavioral Surveillance survey	Behavioral, Knowledge, Attitude and Practice survey	Youth, CSW, MSM	NAP, MOH	Biannually
HATS HIV/AIDS Tracking System	HIV and AIDS by transmission category and clinical presentation	All ages	MOH	Continuous
PAS Patient Administration System	Hospital admission and discharge summary by diagnosis	All hospital visits	MOH	Continuous
NPHL National Public Health Laboratory	All diagnostic tests	All hospital and health facilities users	MOH	Continuous

Source	Data collected	Target group	Responsible	Periodicity
KAPBS Knowledge Attitude Practice and Behavior Survey	(KAPBS) Knowledge Attitude Practice and Behavior Survey	15-49 age group	MOH	Every two to three years
ESS Economic and Social Survey	Annual group and development	Selected social and economic indicators	Planning Institute of Jamaica	Annual
Jamaica Survey of Living Conditions	Household survey on living conditions	Adult population (15-49 age group)	Planning Institute of Jamaica	Annual
(HFLE) Health and Family Life Education	Life skills education in schools	Students in primary school	Ministry of Education, Youth & Culture	Annual
JamStats Database	ChildInfo software collecting health, education information	Adolescents	UNICEF, Statin and PIOJ	Annual
RHS Reproductive Health Survey	Fertility and contraceptive usage prevalence	Women 15-49 age group	National Family Planning Board	Every five years
Jamaica Constabulary Force Statistics Division	Incidents of violence, rape, incest	All age group	Jamaica Constabulary Force	Continuous

The M&E plan was designed to make the most complete possible use of sources already available and systematically and reliably collected. Each of the systems above will be used to the maximum possible to provide data required in the M&E plan. Finally, the monitoring and evaluation system currently used for the HIV/AIDS programme, which records implementation of planned activities and is used to assess project and programme progress, will be adapted for use in the proposed programme.

**38.5. Prepare a table showing the following for each impact, coverage and process indicator listed in section 26: i) the source of data, ii) periodicity of data collection, iii) how the quality of data will be determined/ensured, iv) who (the entity) will be primarily responsible for each indicator, v) and what indicators will be reported through partner organisations.**

Monitoring and Evaluation will be based on the programme components and objectives. Indicators are developed within the framework of these objectives. Input and output indicators will be measured through the monitoring system and their corresponding outcome and impact measure will be captured in baseline and end of programme impact surveys.

Indicator	Data source	Periodicity	Quality Assurance	Responsible Entity	Reported through partner org (Y/N)
<b>Impact level</b>					
HIV seroprevalence rate among young 15-24	DHS (sentinel surveillance-pregnant women)	Annual (only required T1 and T5)	National MOH	MOH/RHA	No
Percentage of HIV-infected infants born to HIV-infected mothers	Two PCR facilities	Annual (Required T1 and T5)	National MOH	MOH/RHA	No

Indicator	Data source	Periodicity	Quality Assurance	Responsible Entity	Reported through partner org (Y/N)
<b>Objective 1: Improve availability and quality of monitoring and diagnostic service for persons infected with HIV/AIDS of all ages</b>					
# of individuals (children and adults) receiving CD4 levels in the public sector, according to national guidelines	National Public Health Lab data base	Annual	MOH	NPHL	No
# of infants born to HIV+ mothers receiving PCR testing according to national standards within the first 6 months 31	National Public Health Lab data base	Annual	MOH	NPHL	No
# of individuals (children and adults) on ARV therapy receiving viral load testing, in accordance with guidelines	National Public Health Lab data base	Annual	MOH	NPHL	No
# of individuals tested for HIV (including pregnant women), in accordance with guidelines	MCSR and obstetrics summary	Quarterly	MOH, SITU	MOH	No
<b>Objective 2: Island-wide provision of counselling and psychological support</b>					
No. of trained counsellors, including community volunteers, providing adherence counselling and psychological support	Reports	Quarterly	PCU	RHA, NGO, PCU	yes
No. of PLWHA trained in counselling and psychological support	Reports	Quarterly	PCU	RHA, NGO, PCU	yes
No. of health care workers trained in counselling and psychological support	Reports	Quarterly	PCU	RHA, NGO, PCU	yes
No. of regional treatment centres with adherence counselling and psychological support	Treatment Center Report	Quarterly	MOH	RHA	No
No. adherence support groups started by NGO/PAC partnerships using trained PLWHA	Reports	Quarterly	NAC	NAC/PAC	yes
<b>Objective 3: Initiate provision of antiretroviral therapy to PLWHA of all ages</b>					
# of individuals (adults and children) with AIDS receiving effective combination ARV according to national guidelines	Treatment Centers Report	Biennial	MOH	MOH/RHA	No

<b>Objective 4: Increase safer sex practices, promote abstinence, and improve attitudes and behaviors among vulnerable groups</b>					
% CSWs use condom last sex with client	KAPB; BSS	Biennial	PCU	PCU	Yes
% MSM who used a condom last sex with a male partner	KAPB; BSS	Biennial	PCU	PCU	Yes
New HIV infections among discordant partners	KAPB; BSS	Biennial	PCU	PCU	Yes
<b>Objective 5: Delay sexual initiation, promote abstinence, and increase condom use among sexually active young people</b>					
Median age first sex	KAPB; BSS	Biennial	PCU	PCU	Yes
% 15-24 correctly ID prevention strategies and reject HIV transmission misconceptions	KAPB; BSS	Biennial	PCU	PCU	Yes
% 15-19 reporting no sexual activity last year	KAPB; BSS	Biennial	PCU	PCU	Yes
% use condom last sex	KAPB; BSS	Biennial	PCU	PCU	Yes
<b>Objective 6: Increase safer sex practices and improve attitudes and behavior in the general population, including persons with disabilities. Men will be a special target of this objective.</b>					
% 15-49 use condoms last sex non-reg partner	KAPB; BSS	Biennial	PCU	PCU	Yes
% 15-49 sex with multiple partners	KAPB; BSS	Biennial	PCU	PCU	Yes
<b>Objective 7: Improve protection of rights of persons living with or affected by HIV/AIDS by developing a comprehensive policy framework</b>					
Approved National HIV/AIDS Policy	Policy	Yr3	Monitoring and Evaluation Reference Group	MOH	NA
Number of large (more than 100 employees) private organisations not requiring pre-employment HIV tests	Survey	Yr 3 and Yr5	Monitoring and Evaluation Reference Group	PCU/UNDP	NA
No. of government ministries adopting and implementing appropriate policies addressing HIV/AIDS	Survey, annual reports	annual	Monitoring and Evaluation Reference Group	PCU	Yes
<b>Objective 8: Reduce stigma and discrimination against persons living with and affected by HIV/AIDS through advocacy and public education</b>					
Level of government expenditure on HIV/AIDS	MOFP	Annual	NA	MOFP	No
# of reported cases of discrimination in educational institutions	MOE Report	Annual	NPC	MOE	No
# of cases of discrimination against PLWHA, MSM, CSW	Report	Annual	PCU	JAS, JN+	Yes

Proportion of population with accepting attitudes towards persons living with or affected by HIV/AIDS	KAPB survey	Yr 3 and Yr 5	MOH	PCU	Yes
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### 38.6. Describe how data will be analysed and used by the PR, CCM, and others

Monitoring of this programme will be performed on a regular basis and will be an integral part of project implementation. The data will be collected at different levels: JCCMHAR Programme level, Parish level, and in the relevant communities. To facilitate monitoring, every implementation unit will develop an annual work plan based on the programme objectives, which will be used as a basis for monitoring. A computerised database will be established to assist with monitoring the indicators and variable outlines in the schedule. Data will be analyzed by gender and geographic location. The inputs will be analysed by the Implementing Agency and the impact/outcome will be analysed by the JCCMHAR.

### 39. Recognizing that M & E plans will make use of existing monitoring systems especially for impact and coverage indicators, national information systems may require strengthening. Please specify activities, partners and resource requirements for strengthening M&E capacities.

*Please note: Total requested from Global Fund should be consistent with the resources needed for Monitoring and Evaluation as indicated in Table V.30.*

*Examples of activities include collecting data, improving computer systems, analyzing data, preparing reports, etc.*

Table VII.39

Activities (aimed at strengthening Monitoring and Evaluation Systems)	Partner(s) (which may help in strengthening M&E capacities)	Resources Required (USD)					
		Year 1	Year 2	Year 3	Year 4	Year 5	Total
Rapid Testing for DHS Sentinel Surveillance of Pregnant Women	National Public Health Laboratory	2400	2400	2400	2400	2400	<b>12,000</b>
Develop Database to track survival rate for AIDS Patients	Ministry of Health	2000	750	750	750	750	<b>5,000</b>
Develop database to assess rate of CD4 and PCR levels testing according to National guidelines	National Public Health Laboratory	1000	500	500	500	500	<b>2,000</b>
Configuration and Analysis of HIV/AIDS Tracking System (HATS)	Ministry of Health	1000	1000	1000	1000	1000	<b>5,000</b>
Database develop to track ARV treatment	Treatment Centres	2000	2000	2000	1000	1000	<b>8,000</b>
Survey Conducted to assess No. of companies who not requiring HIV testing as prerequisite for employment	National AIDS Committee	0	0	2,500	0	2,500	<b>5,000</b>

Database developed to track discrimination in Educational Institutions	Ministry of Education/UWI-HARP	1,000	0	0	0	0	<b>1,000</b>
Discrimination Management Centre Developed	Jamaica Network of Seropositives	62585	74120	74120	0	0	<b>210,825</b>
Commission KAPB Study to assess condom use, infection among discordant partners, HIV misconceptions, delayed sexual behaviour among the young (15 –19)	Ministry of Health	0	0	60,000	0	60,000	<b>120,000</b>
<b>Global Fund M&amp;E request</b>		<b>71,985</b>	<b>80,770</b>	<b>143,270</b>	<b>5,650</b>	<b>68,150</b>	<b>368,825</b>
<b>Unmet need</b>							
<b>Total resources needed</b>		<b>71,985</b>	<b>80,770</b>	<b>143,270</b>	<b>5,650</b>	<b>68,150</b>	<b>368,825</b>

## **SECTION VIII – Procurement and supply-chain management information**

**40. Describe your plans for procurement and supply chain management of health products (including pharmaceutical products, diagnostic technologies and other supplies related to the use of medicines, bednets, insecticides, aerial sprays against mosquitoes, other products for prevention [e.g., condoms], and laboratory equipment and support products [e.g., microscopes and reagents]) integral to this component's proposed disease interventions. The plan should include.**

- i. Procurement responsibilities: A description of whether existing national systems, international or other outsourced procurement agencies, or a mix of both will be used for procurement;
- ii. Procurement practices: A description of how the Interagency Operational Principles for Good Pharmaceutical Procurement will be adhered to, including competitive purchasing from qualified manufacturers and suppliers to obtain the lowest prices for products of acceptable quality; and a description of how performance of suppliers with respect to the quality of goods and services they supply will be monitored;
- iii. Supply chain management: A description of how reliability, efficiency, and security will be assured throughout the supply chain;
- iv. Avoidance of diversion: A description of inventory management, stock control systems, audit systems, and other means to ensure the avoidance of diversion of products;
- v. Forecasting and inventory management: A description of how forecasts of the quantities of health products needed for the programme will be systematically and regularly updated, and how these forecasts will be monitored and regularly compared with actual consumption of these products;
- vi. Product selection: A list of health products to be procured, including reference to the relevant standard treatment guidelines and essential medicines lists of the World Health Organization, host country government or applicant;
- vii. Donation programmes: A description of any donation programmes that are currently supplying health products (or which have been applied for), including

- the Global TB Drug Facility and drug donation programmes by pharmaceutical companies, multilateral agencies, and NGOs;
- viii. Compliance with quality standards: A description of how compliance with quality standards for both multisource and single- or limited-source pharmaceutical products will be assured, including a description of how random samples of pharmaceutical products will be tested for compliance with applicable quality standards;
- ix. Adherence to treatment protocols, drug resistance, and adverse drug reactions: A description of how patients will be encouraged to adhere to prescribed treatment (e.g., use of fixed-dose combinations, once-a-day formulations, blister packs, and peer education and support), how drug resistance will be monitored and contained, and how adverse drug reactions will be monitored;
- x. National and international laws: A description of how national laws and applicable international obligations in the field of intellectual property rights will be complied with, including a description of how the flexibilities provided in the World Trade Organization's Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and referred to in the Doha Declaration on the TRIPS Agreement and Public Health will be used in a manner that achieves the lowest possible prices for products of assured quality;
- xi. Procurement and supply management indicators: A description of indicators to be used to monitor procurement and supply management (e.g., average lead time between product orders and receipt of goods, average percentage of time out of stock of products at principle warehouses and sentinel treatment facilities, price of products in the latest procurement in comparison with prices from the previous procurement of the same products and with median prices reported in international drug price indicators), with baselines if available.

**i. Procurement Responsibilities**

The Ministry of Health will be responsible for all procurement, with the exception of drugs, which will be procured by the Health Corporation Limited (HCL), a government-owned limited liability company established by the Ministry of Health with responsibility for the procurement, warehousing, and distribution of medical supplies for the public sector. Within the Jamaica HIV/AIDS Prevention and Control Project, a Procurement Officer will implement all procurement activities, including procurement planning, procurement processes, contract awards, and maintaining a contract information system. The Executive Director of the JHPCP will oversee all procurement to be carried out within the component.

**ii. Procurement Practices**

The HIV/AIDS Prevention and Control Project is financed by the International Bank for Reconstruction and Development (IBRD) and one of the Loan Agreement conditions is that all procurement within the scope of the Project shall comply entirely with the IBRD Procurement Guidelines and recommended procedures. Procurement and supply chain plans for this component will follow open and fair competition procedures to achieve the highest quality goods and services at the lowest prices. The quality of services provided for in this component will also be monitored and evaluated by the Ministry of Health and the Public Expenditure Division – Projects Unit of the Ministry of Finance and Planning. The JCCMHAR is working with United Nations agencies to strengthen procurement practices of both goods and services.

**iii. Supply Chain Management**

Goods are delivered under cost, insurance and freight (CIF) conditions by overseas suppliers and then thoroughly checked on arrival. They are then insured and transported to HCL's local warehouse, where they are re-examined. The warehouse is zoned and a pharmacy technician, who is accountable for all the goods in his/her zone, controls each zone. This accountability system is also used throughout the distribution system. Internal audits and ad hoc counts are also conducted.

**iv. Avoidance of Diversion**

Products are tagged by HCL according to source of funding and intended recipient/user.

**v. Forecasting and Inventory Management**

HCL utilises a computerised inventory management system that provides historical information on customers' orders and usage. HCL's marketing representatives also visit hospitals to determine changes in therapy that may affect required supplies. The Ministry of Health gathers and collates data on the usage of related drugs and this information is used, in conjunction with information from HCL, for forecasting future needs.

**vi. Product Selection**

The list of health products to be procured was developed based on

- a. WHO's list of essential drugs for the management of OI, HIV/AIDS, TB and STIs;
- b. WHO, CDC, CAREC and draft Jamaican HIV/AIDS treatment guidelines;
- c. Analysis of drugs currently used at hospitals managing HIV/AIDS and common related conditions being seen; and
- d. Quantifications done, based on current numbers of patients being seen in institutions; and projections, based on national statistics.

The list of products includes:

Zidovudine + Lamivudine
Zidovudine + Didanosine
Abacavir
Efavirenz
Nevirapine
Nelfinavir
Didanosine + Stavudine
Lamivudine + Stavudine
Ritonavir/Nelfinavir
Ritonavir/Nelfinavir or Indinavir
Ritonavir/Nelfinavir or Indinavir
Efavirenz or Nevirapine

**vii. Donation Programmes**

Local drug companies have offered to donate Nevirapine for PMTCT and a limited number of triple therapy combinations (20 individuals for three years). Offers of free Nevirapine were also received from Boehringer Ingelheim's Viramune donation programme.

**viii. Compliance With Quality Standards**

The Standards and Regulations Division of the Ministry of Health is responsible for the registration of all suppliers of pharmaceuticals to Jamaica. This registration process includes the testing of products for compliance with applicable quality standards, and suppliers are also required to provide relevant study information. The Standards and Regulations Division, the Jamaica Bureau of Standards, and the Caribbean Drug Testing Laboratory also conduct random testing of samples.

**ix. Adherence to Treatment Protocols**

There are a limited number of patients currently on ARV drugs so there is no structured adherence programme. However, it is hoped that funds from this component will be used to develop an adherence programme in collaboration with pharmacists, NGOs, PLWHA and nutritionists. In developing this programme, similar adherence programmes in other countries will be examined.

**x. National and International Laws**

Domestic legislation is currently being drafted to fully implement patent obligations under the TRIPS Agreement, as the existing law, while protecting the property rights, does not adequately comply with all other TRIPS requirements. The flexibilities provided for in the agreement, including the taking of appropriate measures for the protection of public health, will be utilised.

**xi. Procurement and Supply Management Indicators**

Procurement and supply management will be monitored using the following indicators:

- a) Delivery time by suppliers and compliance with stated terms and conditions;
- b) Cost of clearance - maximum 3% of the value of the shipment;
- c) Clearance time at ports - seven days for non-perishables and two days for perishables;
- d) Expiry date tracking - a minimum of 18 months duration; and
- e) Complaint resolution period.

**41. All procurement of medicines to treat multi-drug resistant tuberculosis financed by the Global Fund must be conducted through the Green Light Committee of the Stop TB Partnership. Please for a Green Light Committee application form in Annex C.**

NA

## LIST OF ATTACHMENTS

*Please note:*

*The list of attachments is divided into two parts: the first part lists the attachments requested by the Global Fund as support for Sections III and IV.*

*The second part is for applicants to list attachments related to other Sections such as the Information on applicants (Section II), Detailed Budget (Section IV), or other relevant information.*

*Please note which documents are being included with your proposal by indicating a document number.*

<b>General documentation:</b>	<b>Attachment #</b>
1. Poverty Reduction Strategy Paper (PRSP)	
• Ministry Paper # 13, 1997 "Jamaica's Policy Towards Poverty Eradication and National Poverty Eradication Programme"	<u>GD1</u>
2. Medium Term Expenditure Framework	<u>NA</u>
3. Sector strategic plans	
• (See Jamaica HIV/AIDS/STI National Strategic Plan, 2002-2006, Time to Care, Time to Act, Ministry of Health)	<u>GD2</u>
4. Any reports on performance	
• National HIV/STI Prevention and Control Programme, 2002 Annual Reports	<u>GD3</u>
<b>HIV/AIDS specific documentation:</b>	<b>Attachment #</b>
5. Situation analysis	
• (See Jamaica HIV/AIDS/STI National Strategic Plan, 2002-2006, Time to Care, Time to Act, Ministry of Health)	<u>GD2</u>
• Report for HIV/AIDS Prevention and Control Program; Health Promotion and Protection Division, Ministry of Health; HIV/AIDS Legal, Ethical and Human Rights Issues in Jamaica, August 2001	<u>HASD1</u>
6. Baseline data for tracking progress <sup>§</sup>	<u>NA</u>
7. National strategic plan for HIV/AIDS, with budget estimates	
• Jamaica HIV/AIDS/STI National Strategic Plan, 2002-2006, Time to Care, Time to Act, Ministry of Health	<u>GD2</u>
8. Results-oriented plan, with budget and resource gap indication (where available)	

<sup>§</sup> Where baselines are not available, plans to establish baselines should be included in the proposal.

<ul style="list-style-type: none"> <li>• First year work plans</li> <li>• Jamaica HIV/AIDS Prevention and Control Project Implementation Plan</li> </ul>	<p><u>HASD2</u></p> <p><b><u>HASD3</u></b></p>
<b>General documentation:</b>	
Jamaica HIV/AIDS Prevention and Control Project (Second Phase of the Multi-Country HIV/AIDS Prevention and Control APL for the Caribbean, Project Appraisal Document, January 2002	<b>Attachment #</b> <u>GD4</u>
Summary of Stakeholders' Meetings, 7-10, April, 2003	<u>GD5</u>
Project Background – Treatment, Prevention, Policy	<u>GD6</u>
Monitoring and Evaluation Framework, August 2002	<u>GD7</u>
JCCMHAR Member:	
<ul style="list-style-type: none"> <li>• Statutes of Organisation</li> <li>• Organisation Background, etc.</li> <li>• Reference Letters</li> <li>• Main Sources of Funding</li> <li>• Organisation Member Lists</li> </ul>	<p><u>GD8</u></p> <p><u>GD8</u></p> <p><u>GD8</u></p> <p><u>GD8</u></p> <p><u>GD8</u></p>
JCCMHAR Meeting Minutes	<u>GD9</u>
Full Proposal Budget	<u>GD10</u>
<b>Crosscutting documents/activities</b>	<b>Attachment # <u>NA</u></b>