

+Jamaica National HIV/AIDS Monitoring and Evaluation System

Monitoring & Evaluation Plan Document A

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Ministry of Health
Jamaica

**Monitoring & Evaluation Plan
The Jamaica National HIV/AIDS/STI Programme**

TABLE OF CONTENTS

1. Introduction	1
2. The National HIV/AIDS/STI Programme Overview	2
2.1 Overview:	2
2.2 Summary Logical Framework	3
2.3 Overview of the National HIV/AIDS/STI M&E System	5
3. HIV/AIDS Indicators.....	6
3.1 Summary of National Focus Indicators	7
3.2 Summary of Complete List of Indicators (including national indicators).....	9
4. Data Collection Plan.....	12
4.1 Routine Data Sources.....	12
4.1a Sentinel Surveillance of ANC and STI Clinic Attendees	13
4.1b HIV/AIDS Tracking System (HATS)	13
4.1c Health Information System	13
4.1d Other Routine Data Sources	15
4.2 Non-routine Data Sources	15
4.2a National KABP Surveys.....	15
4.2b Second Generation Surveillance of MSM and CSW.....	16
4.3 New Data Sources.....	17
4.3a Health Facility Assessment.....	17
4.4 Data Flow	19
4.5 Data Quality Issues.....	20
5. Monitoring & Evaluation Plans.....	21
6. Mechanisms for Monitoring M&E System	22
Performance Objective 1: Develop a National HIV/AIDS M&E Plan.....	22
Performance Objective 2: Implementation of an M&E Plan.....	22
Performance Objective 3: Assessing and upgrading of M&E system capacity	22
Performance Objective 4: Produce High Quality Data on a Timely Basis.....	22
Performance Objective 5: Communicate HIV/AIDS	
7. Mechanism for updating plan.....	22
APPENDIX A: Logical Framework.....	23
Priority Area #1: PREVENTION.....	Error! Bookmark not defined.
Priority Area #2: TREATMENT, CARE & SUPPORT	Error! Bookmark not defined.
Priority Area #3: ENABLING ENVIRONMENT & HUMAN RIGHTS	Error! Bookmark not defined.
Priority Area #4: EMPOWERMENT & GOVERNANCE	Error! Bookmark not defined.
APPENDIX B: Complete Indicator Matrix.....	Error! Bookmark not defined.

Monitoring & Evaluation Plan

The Jamaica National HIV/AIDS/STI Programme

1. Introduction

Monitoring and Evaluation (M&E) is the backbone of public health systems for providing essential information and evidence regarding the best practices and lessons learned in health programmes. The M&E system to collect data and produce information and evidence for the Jamaica National HIV/AIDS/STI Programme is described in two documents: the M&E Plan (Document A) and the M&E Operations Manual (Document B). The M&E Plan is the fundamental document following the National Strategic Plan (NSP). It explains how a programme will measure its achievements and provide for accountability to the stakeholder and donor communities. It builds on the NSP's description of the program objectives and the interventions and further describes the M&E procedures that will be implemented to determine whether or not those objectives are met. The M&E Plan first describes the relationship between the programme's expected outputs, outcomes, objectives and goals. It then describes the data and information required to illustrate this relationship. Next, the M&E Plan details the necessary data sources and data collection systems. The M&E Operations Manual provides programmes with specific guidance on roles, responsibilities, timelines and other implementation factors described in the M&E Plan. It also provides details the value of programme information for decision-making at the local, national and donor levels. The M&E Plan and M&E Operations Manual guide the implementation of M&E activities in a standardized, uniform manner so that programmes can both gather information for day-to-day management, as well as provide information to parish, regional and national efforts. They also provide for programme transparency and preserve institutional memory.

The objectives of the Jamaica National HIV/AIDS/STI Programme M&E Plan are:

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

Furthermore, the Jamaica National HIV/AIDS/STI Programme M&E Plan will include key characteristics of a sound and comprehensive M&E system for a National AIDS Programme as outlined by UNAIDS. These characteristics are listed below:

- Ensure efficient use of data and resources by making sure that indicators and sampling methodologies are comparable over time;
- Avoid duplication through repeat of baseline surveys or evaluation studies by ensuring that generated data serve many constituents, including programme managers, researchers or donors;
- Nationally, make sure that donor-funded M&E efforts best contribute to national needs, rather than simply serving the reporting needs of agencies or legislatures overseas;

- Encourage communication between different groups involved in the national response to HIV. Shared planning, execution, analysis or dissemination of data collection can reduce overlap in programming and increase co-operation between different groups;
- Facilitate ultimate use of data and indicators for programme planning and evaluation. Streamline data collection to focus only on needed data.

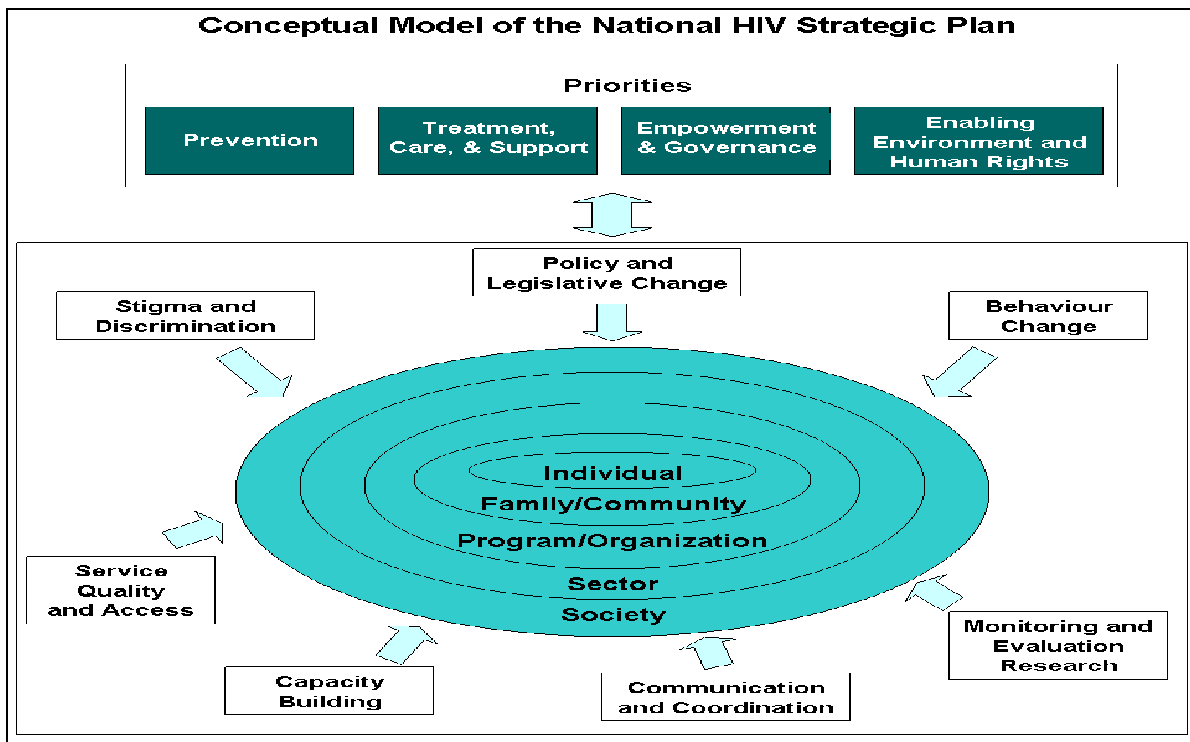
This M&E Plan for the Jamaica National HIV/AIDS/STI Programme is a companion document to the 2007-2011 National Strategic Plan (NSP). Therefore, please refer back to the NSP for detailed information on the programme's specific objectives and interventions. An additional companion document is the Operations Manual. The Operations Manual is intended to be used by stakeholders at all levels that contribute to or participate in the national M&E system, and is designed to clearly detail how each piece of the M&E system functions.

2. The National HIV/AIDS/STI Programme Overview

2.1 Overview:

The goals, objectives and interventions of the NHAPCP are detailed in the NSP. However, the overarching goal of the programme is to achieve universal access to prevention and treatment services by focusing on four priority areas:

1. Prevention;
2. Treatment, Care & Support;
3. Empowerment & Governance; and
4. Enabling Environment & Human Rights.



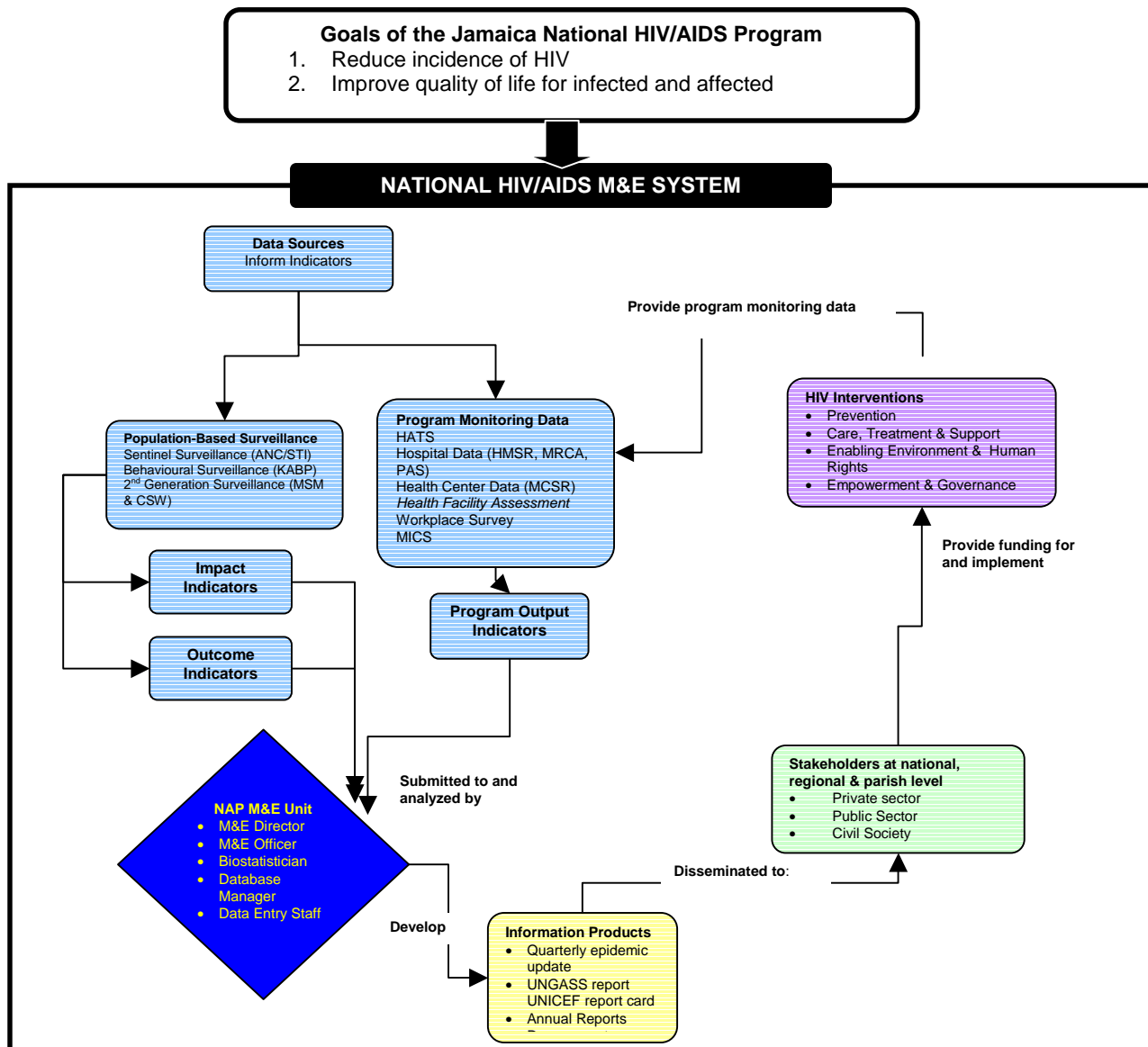
2.2 Summary Logical Framework (*Please see appendix for detailed framework)

	Prevention	Treatment Care & Support	Enabling Environment & Human Rights	Empowerment & Governance
GOAL	To reduce the transmission of new HIV infections <u>Indicators</u> <ul style="list-style-type: none"> Percentage of men & women aged 15-24 who are HIV infected Percentage of CSW who are HIV infected Percentage of MSM who are HIV infected 	To mitigate the impact of HIV/AIDS on the people of Jamaica <u>Indicators</u> <ul style="list-style-type: none"> % of adults or children on ART who are still alive 12 months after initiation of antiretroviral therapy 	To protect fundamental human rights and empower the Jamaican people to make healthy choices <u>Indicators</u> <ul style="list-style-type: none"> Percentage of people 15-49 years expressing accepting attitudes towards people with HIV/AIDS 	To achieve a sustained, effective multi-sectoral infrastructure and commitment to support the National Response to HIV and AIDS <u>Indicators</u> <ul style="list-style-type: none"> National Composite Index
PURPOSE	To achieve universal access to prevention services, focusing on most-at-risk populations <u>Indicators</u> <ul style="list-style-type: none"> Number of individuals reached through TCI disaggregated by vulnerable groups (e.g. youth, MSM, CSW, prisoners, etc.) Number of people trained to provide prevention services to persons most at risk 	To achieve universal access to high quality comprehensive treatment, care and support in an environment that is non-discriminatory and supports adherence <u>Indicators</u> <ul style="list-style-type: none"> % of most-at-risk populations (youth, MSM, CSW (who received HIV testing in the last 12 months & know the results) % of women, men & children with advanced HIV infection who are receiving antiretroviral combination therapy according to national guidelines 	To decrease stigma and discrimination toward people with HIV/AIDS <u>Indicators</u> <ul style="list-style-type: none"> Number and percent of reported cases of HIV-related discrimination receiving redress by setting 	Integration of HIV programs into existing human and social development programs <u>Indicators</u> <ul style="list-style-type: none"> National Composite Index
OBJECTIVES	<p>P1. To increase quality of prevention services</p> <p>P2. To increase accurate information of ways to prevent HIV and dispel myths</p> <p>P3. To identify communities and populations most at-risk</p> <p>P4. To increase access to targeted, age-appropriate HIV prevention services for youth</p> <p>P5. To strengthen prevention efforts for CSW and others engaging in transactional sex</p> <p>P6. To strengthen prevention efforts for MSM</p> <p>P7. To strengthen prevention efforts for tourism workers</p> <p>P8. To strengthen prevention efforts for inmates in correctional facilities</p>	<p>T1. To increase access to HIV testing among priority populations</p> <p>T2. To prevent Mother to Child Transmission of HIV</p> <p>T3. To improve access to and quality of ARV treatment</p> <p>T4. To increase adherence to treatment and care</p> <p>T5. To Improve care and support for Orphans and Vulnerable Children (OVC)</p> <p>T6. To improve access and use of Home Based Care</p> <p>T7. To improve infection control and access to (PEP) for accidentally exposed Health Care Workers</p> <p>T8. To strengthen prevention efforts for PLWHA</p> <p>T9. To improve the management of TB, especially in the HIV infected</p>	<p>E1. To systematically identify and report acts of discrimination</p> <p>E2. To improve public awareness of HIV and AIDS</p> <p>E3. To strengthen community advocacy against stigma and discrimination</p> <p>E4. To reduce stigma in all sectors</p> <p>E5. To reduce stigma and discrimination in the health sector</p> <p>E6. To empower youth to address stigma and discrimination</p> <p>E7. To empower PLWHA in the context of reducing stigma and discrimination and seeking treatment and care</p> <p>E8. To advocate for legislation that protects human rights</p> <p>E9. To advocate for non-discrimination among management and employees of the insurance sub-sector</p>	<p>G1. To build capacity and commitment of health sector to recognize their role and provide high-quality services for all people</p> <p>G2. To build capacity and commitment of other sectors</p> <p>G3. To develop one monitoring and evaluation framework</p> <p>G4. To improve procurement and financial management systems</p> <p>G5. To implement a sustainability plan</p> <p>G6. To assure multi-sectoral commitment to National Strategic Plan</p> <p>G7. To assure strong governance and accountability</p>

	Prevention	Treatment Care & Support	Enabling Environment & Human Rights	Empowerment & Governance
<p>OBJECTIVES (continued)</p>	<p>P9. To increase prevention interventions in the labour sector directed at reducing stigma & discrimination P10. To strengthen prevention efforts for persons within the uniformed services P11. To strengthen HFLE program in the education sector (early childhood to tertiary) P12. To strengthen the capacity of the sectors in the national response to conduct prevention interventions P13. To reduce transmission from PLWHA to their partners and secondary infections P14. To improve prevention interventions for drug abusers P15. To increase the use of mass media in prevention efforts P16. To identify cultural influencers who can positively shift existing risky cultural norms P17. To strengthen prevention efforts for vulnerable adolescents <u>Indicators</u></p> <ul style="list-style-type: none"> • % of young people (15-24) or at risk groups who correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions • % of young adults, 15 to 19 years old, who have never had sex • % of young men & women aged 15-24 reporting condom use the last time they had sex with a non-regular partner • % of CSW reporting condom use the last time they had sex with a client • % of MSM reporting using a condom the last time they had anal sex with a male partner • Number of people trained to provide prevention services to persons most at risk 	<p>T10. To strengthen the management of STI, including syphilis T11. To improve the diagnostic capacity of the laboratory services T12. To strengthen and institutionalize the training programme <u>Indicators</u></p> <ul style="list-style-type: none"> • % of most-at-risk populations (youth, MSM, CSW (who received HIV testing in the last 12 months & know the results) • % of women, men & children with advanced HIV infection who are receiving antiretroviral combination therapy according to national guidelines • % of infants born to HIV-infected mothers [who are HIV-infected] • % of PLWHA on ARV reporting at least 90% adherence by pill count • Ratio of current school attendance among orphans to non-orphans, aged 10-14 • Number of persons trained to provide treatment services by client and service area • Proportion of confirmed TB cases tested for HIV • % of HIV positive TB patients who began or continued ARV during TB treatment • Incidence of congenital syphilis • % of persons with STIs managed appropriately as per Syndromic Management protocol 	<p><u>Indicators</u></p> <ul style="list-style-type: none"> • Number of persons trained by client and service area • Percentage of large enterprises/ companies that have HIV/AIDS workplace policies and programs • Number of policy makers attending sensitization workshops on HIV/AIDS/STI 	<p><u>Indicators</u></p> <ul style="list-style-type: none"> • Number of persons trained by client and service area • Number of individuals trained in strategic information (M&E and/or surveillance and/or HMIS) • Number of NGOs providing HIV/AIDS prevention or treatment, care and support services according to national guidelines/ standards • Percentage of schools with teachers who have been trained in life-skills based HIV/AIDS education and who taught it during the last academic year • Number of policy makers attending sensitization workshops on HIV/AIDS/STI

2.3 Overview of the National HIV/AIDS/STI M&E System

In agreement with global leaders in the fight against HIV/AIDS to provide one national monitoring and evaluation plan, the NHAPCP has developed a conceptual model to illustrate the various components of the M&E system and how they are interrelated to provide information for programmes.



The system diagram illustrates how information is generated from special surveys and program monitoring data. These data inform specific indicators which provide information to local programme units, parishes, regional managers, and the National AIDS Programme. The information is presented through various publications and reports on a regular basis. The M&E

system benefits every contributor by providing information on various levels to improve programmes and policies around HIV/AIDS.

3. HIV/AIDS Indicators

Indicators are variables that measure one aspect of a program or project related to the program's objectives. Indicators provide M&E information crucial for decision-making at every level and stage of program implementation. The NHAPCP, in collaboration with its stakeholders, has selected a set of Core National Indicators (Section 3.1) to inform management of the National HIV/AIDS/STI Programme. However, there are also several donors that contribute both financially and technically to the national HIV/AIDS program and the donors require reporting of some additional indicators that are not focus indicators for the program. Section 3.2 provides a complete list of all of the indicators, both global and national, on which the program must collect data and report. (Please see Appendix B for a detailed matrix including data source, frequency, persons responsible, baselines, targets, and data tool development).

The Jamaica M&E system collects data on indicators at several levels: global, national, and local. Each level in the system has different data needs and will use the indicators differently.

Global indicators are required to sustain donor support and help provide a reflection of the current HIV/AIDS situation throughout the world. In order for global indicators to be meaningful across countries, all must agree on what the indicator means, how to measure it, and must record it in the same way. Examples of global indicators for which Jamaica collects data are those reported to UNGASS, the World Bank, the Global Fund and PEPFAR.

The Jamaica National HIV/AIDS/STI Program has a list of indicators that are used to help set the national health agenda and to monitor program effects. These are national focus indicators. Many of these indicators overlap with global indicators.

Facility-level indicators provide more detailed, local-level information to help programme planners decide how best to address the challenges, such as scarce resources, while meeting the needs of its clients. They provide information on whether or not the target population is being reached, how well services are being provided, and whether or not sufficient resources exist to be able to provide adequate services. These are usually not required for program management at the national level.

Uses for the indicators:

Client monitoring information can be used for intervention-related decision making. **Information is only good when it is used.** Data that are not useful or that cannot be used should not be collected. Often, it is not that the data itself are useless, but that more training is needed on how to use it effectively.

Global indicators are used by donors for decisions regarding:

- Realistic international 5-year targets
- Funding allocation
- International conferences and meeting agendas

National indicators have been identified to inform decision and policy makers on:

- The level of donor commitment, and when high-level negotiations and changes are necessary
- How well the national system is functioning, and where additional support and training are needed

At the local level, indicators can provide information for managers and planners that will help to determine:

- Priority target groups
- How to most effectively allocate limited funding (programs, supplies, staff, etc.)
- Types of outreach activities that are needed
- Barriers to accessing prevention and treatment services

3.1 Summary of Core National Indicators

The indicators listed below are only those used to monitor and evaluate the NHAPCP. Some of these indicators overlap with the global indicators.

Priority Area 1: PREVENTION		
NSP	Other code	Indicators
GOAL	UN-GE 15	Percentage of men and women aged 15 to 24 that are HIV infected
GOAL	UN-C/LPE 9a	Percentage of CSW who are HIV infected
GOAL	UN-C/LPE 9b	Percentage of MSM who are HIV infected
PURPOSE	USJ 9	Number of individuals reached through TCI disaggregated by vulnerable groups (e.g. youth, MSM, CSW, prisoners, etc.)
PURPOSE, P7-P10, P12, P16		Number of persons trained to provide services by client and service area
P2	UN-GE 10	Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
P4, P11, P15, P17		Percentage of young adults, 15 to 19 years old, who have never had sex
P4, P15 (15-24 yrs)		% of young women and men aged 15-24 reporting the use of a condom the last time they had sex with a non-regular partner
P5	UN-C/LPE 4	Percentage of CSW reporting using a condom at last sex act with client
P6	UN-C/LPE 5	Percentage of MSM reporting using a condom the last time they had anal sex with a male partner

Priority Area 2: TREATMENT, CARE & SUPPORT		
GOAL	UN-GE 16	Percentage of adults and children with HIV still alive 12 months after initiation of ART
PURPOSE, T1	UN-C/LP 3	Percentage of most-at-risk populations (youth, MSM, CSW) who received HIV testing in the last 12 months and who know the results
PURPOSE, T3	GF 23	Percentage of women, men and children with advance HIV infection who are receiving antiretroviral combination therapy according to national guidelines
T2	UN-GE 17	Percentage of infants born to HIV-infected mothers [who are HIV-infected]
T4		Percentage of PLWHA on ARV reporting at least 90% adherence by pill count
T5	UN-GE 14	Ratio of current school attendance among orphans to that among non-orphans aged 10-14
T8, T12		Number of persons trained to provide services by client and service area
T9		Proportion of confirmed TB cases tested for HIV
T9		Percentage of HIV positive TB patients who began or continued ARV during TB treatment
T10		Incidence of congenital syphilis
Priority Area 3: ENABLING ENVIRONMENT & HUMAN RIGHTS		
GOAL	GF 42	Percentage of people 15-49 years expressing accepting attitudes towards people with HIV/AIDS
PURPOSE, E5		Number and percent of reported cases of HIV-related discrimination receiving redress by setting
E4	UN-GE 4	Percentage of large enterprises/ companies that have HIV/AIDS workplace policies and programs
E8		Number of policy makers attending sensitisation workshops on HIV/AIDS/STI
	PEPFAR	Number of local organizations provided with technical assistance for HIV-related policy development
Priority Area 4: EMPOWERMENT & GOVERNANCE		
GOAL, PURPOSE	UN-GE 2	National Composite Policy Index
G3	PEP 4.9	Number of individuals trained in strategic information (M&E and/or surveillance and/or HMIS)
G6		Number of NGOs providing HIV/AIDS prevention, treatment, care and support services according to national guidelines/standards
G7		Number of policy makers attending sensitization workshops on HIV/AIDS/STI

3.2 Summary of Complete List of Indicators (including national focus indicators in bold)

Priority Area 1: PREVENTION	
IMPACT	
UN-GE 15	Percentage of men and women aged 15 to 24 that are HIV infected
UN-C/LPE 9a	Percentage of CSW who are HIV infected
UN-C/LPE 9b	Percentage of MSM who are HIV infected
WB 1	Syphilis sero-prevalence among ANC attendees 15 to 24 yrs
WB 2a	HIV prevalence among ANC attendees 15-24 years
WB 2c	HIV Prevalence among Army recruits
WB 2d	HIV prevalence among 15-49 year olds in Kingston
CAR 1	Prevalence of HIV among STI clients
CAR 2	AIDS Case rate
OUTCOME	
GF4	% of people by sex and age groups who reported condom use at last intercourse with non-regular partner
UN-C/LPE 4	Percentage of CSW reporting using a condom at last sex act with client
UN-C/LPE 5	Percentage of MSM reporting using a condom the last time they had anal sex with a male partner
UN-GE 10	Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
	Percentage of young adults, 15 to 19 years old, who have never had sex
UN-GE 9	Percentage of transfused blood units screened for HIV
UN-GE 11	Median age at first sex for men and women
UN-GE 12	Percentage of young women and men aged 15-24 who had sex with a non-marital, non-cohabiting sexual partner in the last 12 months
GF 7	Percentage of youth 15-19 years who reported no sexual activity in the last 12 months
GF 8	Percentage of 15-49 year olds who reported having sex with multiple partners in the last 12 months
CIMT 3	% of people 15-49 years old who can access a condom almost immediately (less than 5 minutes)
OUTPUT & PROCESS	
USJ 9	Number of individuals reached through TCI including vulnerable groups (e.g. youth, MSM, CSW, prisoners, etc.)
	Number of persons trained to provide services by client and service area
WB 6	Number of peer educators trained for each high risk group (CSW, MSM, prisoners, out-of-school youth)
GF 39	Number of commercial sex workers and MSM reached through prevention activities
GF 40	Number of service deliverers trained on HIV/AIDS prevention
PEP 4.1	Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful
PEP 4.2	Number of individuals trained to promote HIV/AIDS prevention <i>beyond</i> abstinence and/or being faithful
PEP 4.13	Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment
PEP 5.1	Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful.
PEP 5.2	Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behaviour change <i>beyond</i> abstinence and/or being faithful

Priority Area 2: TREATMENT, CARE & SUPPORT

IMPACT	
UN-GE 16	Percentage of adults and children with HIV still alive 12 months after initiation of ART
UN-GE 17	Percentage of infants born to HIV-infected mothers [who are HIV infected]
OUTCOME	
UN-GE 14	Ratio of current school attendance among orphans to that among non-orphans aged 10-14
UN-C/LP 3	Percentage of most-at-risk populations (youth, MSM, & CSW) who received HIV testing in the last 12 months and know the results
GF 23	Percentage of women, men and children with advance HIV infection who are receiving antiretroviral combination therapy according to national guidelines
	Percentage of PLWHA on ARV reporting at least 90% adherence by pill count
	Proportion of confirmed TB cases tested for HIV
	Percentage of HIV positive TB patients who began or continued ARV during TB treatment
	Incidence of congenital syphilis
WB 9	Percentage of ANC clients that are counselled and tested for HIV
WB 10	Percentage of public sector clinicians of AIDS patients who manage OIs in adults according to national guidelines
UN-GE 6	Percentage of HIV positive pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT
UN-GE 8	Percentage of orphans and vulnerable children (boys/girls) whose households received free basic external support in caring for the child
GF 19	Number of individuals tested for HIV according to guidelines
GF 21	Number of infants born to HIV+ mothers receiving PCR testing according to national standards
GF 24	Number of individuals (children & adults) receiving CD4 tests in the public sector according to national guidelines
GF 25	Number of individuals (children & adults) on ART receiving viral load testing in accordance with guidelines
OUTPUT & PROCESS	
	<i>Number of persons trained to provide services by client and service area</i>
WB 7	Percentage of health districts with at least one trained counsellor providing VCT counselling
WB 8	National Public Health Lab turn-around time for HIV testing
GF 26	Number of public sector sites offering ARVs
GF 27	Number of PLWHA receiving adherence counselling
GF 32	Number of adherence support groups started by NGO/PAC partnerships using trained PLWHAs

Priority Area 3: ENABLING ENVIRONMENT & HUMAN RIGHTS

OUTCOME

UN-GE 4	Percentage of large enterprises/ companies that have HIV/AIDS workplace policies and programs
GF 35	Number of cases of HIV related discrimination reported by setting
GF 42	Percentage of people 15-49 years expressing accepting attitudes towards people with HIV/AIDS
	Number and percent of reported cases of HIV-related discrimination receiving redress by setting
GF 33	Number of large (>100 employees) private organizations not requiring pre-employment HIV tests

OUTPUT & PROCESS

	<i>Number of persons trained to provide services by client and service area</i>
	Number of policy makers attending sensitisation workshops on HIV/AIDS/STI
PEP 3.1	Number of organizations provided with technical assistance for HIV-related policy development
PEP 3.2	Number of local organizations provided with technical assistance for HIV-related institutional capacity building
PEP 4.10	Number individuals trained in HIV-related policy development
PEP 4.11	Number individuals trained in HIV-related institutional capacity building

Priority Area 4: EMPOWERMENT & GOVERNANCE

OUTCOME

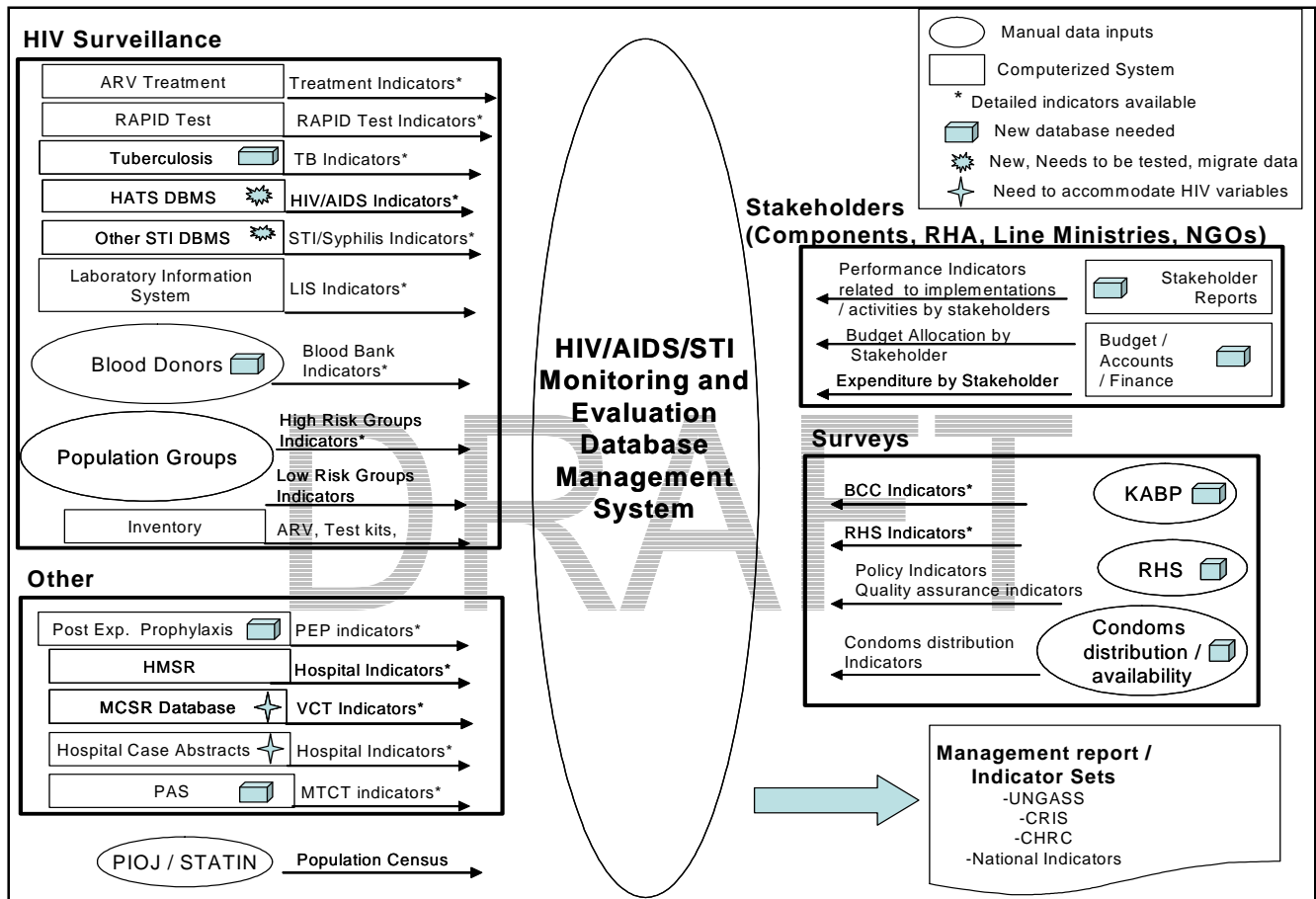
UN-GE 2	National Composite Policy Index
WB 15	Percentage of project funding disbursed for HIV activities utilized by NGOs, CBOs, FBOs
WB 16	Annual project funding disbursed by RHAs and parishes for HIV/AIDS activities
WB 17	Recurrent second generation surveillance of: general population; vulnerable populations
UN-GE 1	Amount of national funds disbursed by government for HIV

OUTPUT & PROCESS

	<i>Number of persons trained to provide services by client and service area</i>
PEP 4.9	Number of individuals trained in strategic information (M&E and/or surveillance and/or HMIS)
UN-GE 3	Percentage of schools with teachers who have been trained in life-skills based on HIV/AIDS education and who taught it during the last academic year
	Number of NGOs providing HIV/AIDS prevention, treatment, care and support services according to national guidelines/standards
	Number of policy makers attending sensitisation workshops on HIV/AIDS/TB
WB 13	Management Information System developed for routine reporting (M&E Unit in MOH and Regional Authorities)
WB 14	MIS developed including computerization of National Public Health Lab (LIS), surveillance system (HATS) and regular reporting
PEP 2.1	Number of local organizations provided with technical assistance for strategic information activities (M&E and/or surveillance and/or HMIS)
CIMT 5	Number of individuals trained in HIV-related community mobilization and for prevention, care and/or treatment (male & female)
CIMT 6	Number of indigenous organizations provided with technical assistance for HIV-related institutional capacity building

4. Data Collection Plan

The NHAPCP has multiple data sources and collection systems in place and under development that contribute to the M&E system. The M&E Plan and Operations Manual document the harmonization of these data sources and collection systems to reduce duplicate reporting and improve data quality. The relationships between key data collection mechanisms of the M&E information system have been visualized below:



4.1 Routine Data Sources

Routine data sources provide data that are collected on a continuous basis, such as information that clinics collect on the patients utilizing their services. Although these data are collected continuously, they are generally aggregated and reported periodically, for instance, aggregated monthly and reported quarterly. Examples of routine data sources within the NHAPCP and the indicators which they inform are discussed in the following sections. Data collection from routine sources is useful because it can provide information on a timely basis. However, it can be difficult to obtain accurate estimates of catchment areas or target populations through this method, and the quality of the data may be poor because of inaccurate record keeping or incomplete reporting.

4.1a Sentinel Surveillance of ANC and STI Clinic Attendees

The overall purpose of the HIV sentinel surveillance system is to monitor the trends in prevalence in some high risk groups in the country. Its main components are HIV sero-prevalence surveys among antenatal care and STI sentinel group.

At the health centre level, a rapid test is applied or in some cases, the blood specimen is sent to a testing site within the parish. Positive rapid tests are then sent for testing by the ELISA method at a regional laboratory, or the National Public Health Laboratory if there is no referral laboratory in the region.

What does the National M&E System need from this data source?

- **Percentage of men & women aged 15 to 24 that are HIV infected**
- HIV prevalence among ANC attendees 15-24 years
- HIV prevalence among 15-49 year olds in Kingston
- Prevalence of HIV among STI clients

Frequency of Data Collection and Reporting:

Sentinel surveillance involves testing 15-49 year old persons who attend ANC or STI clinics, typically between April and September of that year. This information is collected every 2 years.

4.1b HIV/AIDS Tracking System (HATS)

HATS is an ongoing HIV surveillance system based on confidential case reporting, which includes demographic information, mode of transmission, risk factors, and stage of infection. The M&E Unit receives case reports from health services, public and private, on newly diagnosed HIV/AIDS cases. In addition, the surveillance officer based at the National HIV/AIDS Program **actively** visits hospitals, private practitioners, hospices, death registries, among others, to identify and complete HIV/AIDS case reports. These case reports are entered into the HATS database, which is routinely searched for double entries and revised periodically based on updates from the surveillance officer or contact investigators. The database is used to obtain national HIV prevalence estimates and other national statistics.

What does the National M&E System need from this data source?

- AIDS Case rates
- Number of AIDS deaths

Frequency of Data Collection and Reporting:

Data are collected and entered in an on-going basis. Standard reports are generated quarterly.

4.1c Health Information System

The Jamaican Health Information System in its present form consists of a few stand-alone databases. The databases are directly managed by the Planning and Evaluation Department of the Ministry of Health and consist of data collected from the following two service delivery levels:

Hospitals:

Hospital Monthly Statistical Report (HMSR) database – reports on workload information within the hospital system

Medical Records Case Abstract (MRCA) database – stores patient demographics and information on diagnostic procedures, and discharge diagnoses

Patient Administration system (PAS) – stores patient demographics and information on admission, diagnostic procedures, and discharge

Health Centres:

Monthly Clinical Summary Report (MCSR) database – stores aggregate information on services including antenatal, postnatal, child health, Family Planning etc.

Combined Immunization database

Community Mental Health database

Currently, there are 24 hospitals and 344 health centres across the 4 administrative regions of the island. Data from these two service delivery levels is aggregated on paper-based forms and sent directly to the Office of Planning and Evaluation. All of the above databases, with the exception of the MRCA, report monthly summaries on paper-based forms. The MRCA, however, tracks actual patient information based on the Taxation Registration Number (TRN), which, again, has its own limitations as a unique patient identifier.

Three of the above databases are on an older *FoxPro* based platform and have undergone minimal upgrading over the past five years. The only two databases implemented in more standard *MS Access* include the Immunization database and the MRCA database. There is a proposal to upgrade all systems under a unified MIS and with online connectivity. It is currently at the stage of defining user requirements. Successful implementation of the project is contingent upon timely availability of funding and buy-in from upper management.

At this time, the MCSR form has been revised to accommodate a few HIV related indicators. However, the form has not yet been implemented through the health system due to the obvious challenges involved in introducing a new form and the need to first have an upgraded MCSR database in place before starting to collect data using the new form. It is more than likely that as a fallback option the M&E unit will have to collect HIV data through other channels so that the NAP program is able to report on output indicators.

What does the National M&E System need from this data source?

- Percentage of HIV positive pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT
- Percentage of ANC clients that are counselled and tested for HIV
- Syphilis sero-prevalence among ANC attendees 15-24 years
- Number of individuals tested for HIV according to guidelines

Frequency of Data Collection and Reporting:

Data are collected by the facilities in an on-going basis. Quarterly, the data are collated and sent to the regional HIV coordinators who complete the Regional HIV/AIDS Summary Report, which is sent to the M&E Unit at the MOH.

4.1d Other Routine Data Sources

There are several other routine data sources that are at various stages of development. Many of these data sources are managed outside of the Ministry of Health and may even be outside of the health sector, but provide valuable information for the overall HIV/AIDS M&E system.

Data Source	Development Status	Frequency of Reporting
Army Records	Developed	
JN+ Stigma Database	In development – have standardized form	
National Health Fund Database	In development	<i>Annual</i>
NBTS & Public Health Lab	Developed	Quarterly report of number of HIV tests by group: Risk category ANC STI Outreach Hospital Region Sex Age
VCT Records	Not developed	<i>Quarterly</i>
PEPFAR	Developed	<i>Annual</i>
Stakeholder Reports	In development – currently, information comes from finance	<i>Monthly</i>

4.2 Non-routine Data Sources

Non-routine data sources provide data that are collected on a periodic basis, usually annually or less frequently.

Using non-routine data avoids the problem of incorrectly estimating the target population when calculating coverage indicators. Another advantage is that both those using and those not using health facilities are included in the data.

Non-routine data have two main limitations: collecting them is often expensive, and this collection is done on an irregular basis. In order to make informed program decisions, program managers usually need to receive data at more frequent intervals than non-routine data can accommodate.

4.2a National Knowledge, Attitudes, Behaviour and Practices (KABP) Surveys

The National HIV/AIDS Program conducts a National Knowledge, Attitudes, Behaviour and Practices (KABP) population-based survey every 3-4 years. The last KABP was conducted in 2004 and the next one is schedule to be implemented in 2007. The survey obtains information on the knowledge and practices related to the prevention and transmission of HIV and other STIs.

These surveys have provided national level measures of outcome indicators and have focused on partner reduction, consistent use of condoms in regular and non-regular partnerships, delay of sexual activity among young persons, myths and appropriate practices regarding STI/HIV/AIDS, knowledge and awareness of STI, and condom accessibility.

The surveys have been implemented under a sub-contract agreement with a local contractor.

The sampling methodology is by clusters, using Enumeration Districts (EDs). The EDs are selected with probability proportionate to their size (measured in terms of the number of dwelling per ED). An equal number of dwellings are selected from each ED using a systematic sampling with a random start. For purpose of selection of the EDs, all EDs of the population census (after grouping them where necessary such that no ED contains less than 80 dwellings) are grouped into 234 strata (also called sampling regions) of equal size (again measured in terms of the number of dwellings). Every stratum contains approximately 25,000 dwellings and the EDs are selected from each sampling region with probability proportionate to its size.

The design which is also called the “paired selection design” has stood the test of time and has been adopted for the sample selection. The target groups have been male and female 15-24 years, and 25-49 years. Data is collected in confidential face to face interviews by trained interviewers. The design used is a stratified multi-staged sample with quota control for gender. The rural/urban composition of this sample is generally representative of the country.

What does the National M&E System need from this data source?

- **Percentage of people by sex and age groups who reported using a condom at last sex with a non-regular partner**
- **Percentage of young adults, 15 to 19 years old, who have never had sex**
- **Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission**
- **Percentage of people 15-49 yrs expressing accepting attitudes towards people with HIV/AIDS**
- Percentage of young women and men aged 15-24 who had sex with a non-marital, non-cohabiting sexual partner in the last 12 months
- Percentage of 15-49 year olds who reported having sex with multiple partners in the last 12 months
- Female and male median age at first sex
- % of people 15-49 years old who can access a condom almost immediately (less than 5 minutes)
- Percentage of 15-49 year olds who reported having sex with multiple partners in the last 12 months

Frequency of Data Collection and Reporting

The National HIV/AIDS Program conducts a National Knowledge, Attitudes, Behaviour and Practices (KABP) population-based survey every 3-4 years. The last KABP was conducted in 2004 and the next one is schedule to be implemented in 2007.

4.2b Second Generation Surveillance of MSM and CSW

These surveys provide national level measures of outcome indicators and prevalence rates in high risk groups such as youth, MSM and CSW. They focus on use of condoms with regular and non-regular partners, myths and appropriate practices with regards to STI/HIV/AIDS, exposure to interventions, and other high risk behaviours such as substance abuse.

Data are collected by structured questionnaires. The youth surveys (Healthy Lifestyles) were school-based and population-based samples of 10-15 year olds and 15-19 year olds. The MSM

and CSW surveys are modifications of the PLACE methodology. Biological samples are also collected for HIV testing for MSM and CSW.

What does the National M&E System need from this data source?

MSM:

- **Percentage of MSM who received HIV testing in the last 12 months and who know the results**
- **Percentage of MSM who are HIV infected**
- **Percentage of MSM reporting using a condom the last time they had anal sex with a male partner**

CSW:

- **Percentage of CSW who received HIV testing in the last 12 months and who know the results**
- **Percentage of CSW who are HIV infected**
- **Percentage of CSW reporting using a condom at last sex act with client (paying partner)**

Frequency of Data Collection and Reporting

Healthy Lifestyles data were collected in 2005 for the 10-15 year old survey and in 2006 for the 15-19 year old survey. The most recent CSW study was done in 2005 and there is currently another one underway, which should be completed in 2007. There is also an MSM study in the field and final reports should be available by the end of 2007. These studies will be conducted every two to three years, depending on availability of funding.

4.3 New Data Sources

In addition to the specific instruments and methodologies listed above, the M&E Unit has gained access to additional data sources or will implement other data collection activities over the next few years to obtain data that are not covered by any of the above tools.

The following are some of the newly conducted or proposed studies/data activities:

NEW DATA SOURCE	FREQUENCY	IMPLEMENTATION	INSTITUTIONAL RESPONSIBILITY
Health facility survey	Biannual	No	M&E Unit
Workplace survey	Biennial	2005	Ministry of Labour
MICS (Multiple Indicator Cluster Survey)	Every 5 years	2005	UNICEF
National HIV/AIDS database secondary data analysis	Once	2007	M&E Unit
Develop a National HIV/AIDS M&E 10 Years Report of HIV/AIDS/STI in Jamaica	Once	No	M&E Unit

4.3a Health Facility Assessment

The Objective of Health Facility Assessment (HFA) is to determine whether the health centres and hospitals are capable of providing quality HIV/AIDS and STI services, and if not, what materials, equipment and training they need to full fill this goal.

The HFA will provide information on the following indicators:

- **Percent of women and men with STIs at health care facilities who are managed appropriately according to Syndromic Management protocol**
- Percent of public sector clinicians of AIDS patients manage OIs in adults according to national guidelines

The specific objectives of the HFA are:

- To establish whether the health facilities have the necessary infrastructure and equipment to deliver quality services; i.e., counselling materials and protocols, testing kits, IEC and job-aids, among others;
- To establish the clinical and management skills of health care personnel;
- To coordinate efforts with other health services and private practitioners by parish and region

Frequency of Data Collection and Reporting

The Health Facility Assessment has not yet been implemented, but it is intended to be done biannually.

The frequency of HFA will be every two years, but will be contingent on the needs of the Jamaica National HIV/AIDS/STI Program. Ideally, it will be carried out together with population-based surveys, so that information can be triangulated to obtain information of both community interventions and service delivery.

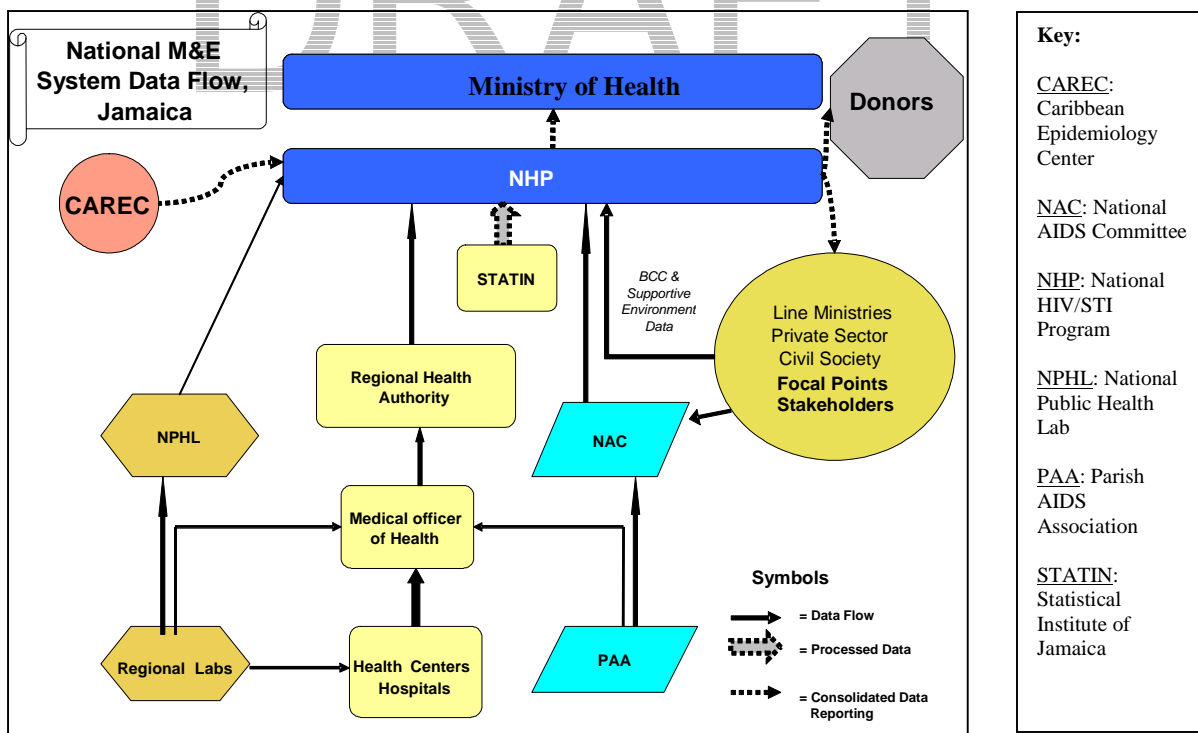
The HFA will be conducted at health centres and hospitals, which will be randomly selected from the 4 regions. When possible, MOH qualified staff from local and regional level will be responsible for data collection and supervision. They will be trained as surveyors and supervisors.

The tools (observation check lists, exit interviews, health care worker interview and equipment and supplies checklist) will be designed and pre-tested according to the Jamaica HIV/AIDS/STI Program needs. The data will flow from health facilities to parishes and from there to the regions, which will send the information to the HIV/AIDS/STI Program M&E Unit. The information collected will be used at Parish, Regional and National levels to plan strategies and activities for improving the program.

4.4 Data Flow

Typically, national M&E systems focus primarily on data collection and reporting up to national leaders and international donors. That is, local data support national and donor level analyses and reports, but are not used locally. This one-directional flow misses opportunities to provide valuable feedback to regional and local programmes. These missed opportunities may prevent local programmes from making simple mid-course corrections that could positively impact the health of their communities. Additionally, if information is not uniformly available so that it can be accessed and used by local programmes, there is little incentive to report quality data in a timely manner.

The MOH and other stakeholders in the National AIDS Programme have recognized the importance of timely and accurate local level data and the use of that data by the data collectors as part of a fully functioning M&E system. Below is a diagram of data within the National M&E system flow between data collector and information user. This diagram was developed for the 2001-2006 National Strategic Plan. In the past year (2006-2007), the strengthening of the M&E Resource Group (MERG), the development of the M&E Working group, and additional technological advances (e.g., improved MOH website management) have improved the ability for national and regional level data users to provide information back to the local level, although more work will be done in the future. The NHAPCP has included revised procedures, information products, and information flow maps for each programme area in the M&E Operations Manual to further assist local facilities and programme managers in accessing the system's information.



4.5 Data Quality Issues

Data quality needs to be monitored and maintained throughout the data collection process. Potential biases should be considered, identified and adjusted for before data collection begins, and then monitored throughout. Obviously data are most useful when they are of the highest quality; however, data quality often requires a trade off with what is feasible to obtain. The highest quality of data is usually obtained through the triangulation of data from several sources.

It is also important to remember that behavioural and motivational factors on the part of the people collecting, collating, analyzing and reporting on the data can also affect the quality. Examples of common biases in data collection include:

Sampling bias: occurs when the sample taken to represent population values is not a representative sample

Non-sampling error: all other kinds of mis-measurement, such as courtesy bias, incomplete records, or non-response rates

Subjective measurement: occurs when the data are influenced by the measurer

For each data set, the following data quality issues should be considered:

Coverage: Will the data cover all of the elements of interest? If not, what other data sets can be used to triangulate?

Completeness: Is there a complete set of data for each element of interest? If not, what is missing? Could missing data be obtained easily? What changes could be made to the system to solve this problem?

Accuracy: Have the instruments been tested to ensure validity and reliability of the data?

Duplication: Are the same people being counted more than once? What mechanism is in place to control for this?

Frequency: Are the data collected as frequently as needed, at each level? While the national program may only need the data annually, how often do regional or parish programs need the data?

Reporting Schedule: Do the available data reflect the time periods of interest? How do we reconcile different requests (i.e. US Federal Fiscal Year, Calendar Year, etc?)

Accessibility: Are the data needed collectable/retrievable? What are the barriers?

Power: Is the sample size big enough to provide a stable estimate or detect change?

5. Monitoring & Evaluation Tasks

<u>Tasks</u>	2007	2008	2009	2010	2011	2012
Redefine targets for NSP						
Create targets for NSP indicators	X					
Distribute targets to MERG	X	X				
M&E Plan Development & Tools						
Distribute M&E Plan & Operations Manual to M&E Working Group for review	X	X				
Introduce Operations Manual and provide training on data collection, data quality and data use at the regional level		X	X			
Develop data quality monitoring plan		X				
Incorporate decision calendar and other DDIU tools into practice, as necessary		X				
Data Collection & Analysis						
<u>Routine Data</u>						
Finalize data collection forms with review committee	X	X				
Sentinel Surveillance - ANC	X		X		X	
Sentinel Surveillance – STI	X		X			
HATS	X	X	X	X	X	X
PEPFAR Reporting	X	X	X	X	X	X
Non-Routine Data						
KABP	X				X	
MSM Survey	X		X		X	
CSW Survey		X		X		X
Health Facility Assessment		X		X		X
MICS			X			
Workplace Survey	X		X		X	
National Composite Index	X		X		X	
Information Products						
AIDS Report Epidemic Update	X	X	X	X	X	X
HIV Bulletin	X	X	X	X	X	X
UNGASS report	X	X	X	X	X	X
UNICEF report card	X	X	X	X	X	X
Reports to Donors	X	X	X	X	X	X

6. Mechanisms for Monitoring M&E System

In the true spirit of M&E, transparency and accountability, the M&E System, as described by this plan and supporting documents, will be monitored based on a set of Performance Objectives. The objectives and related indicators will be reviewed annually by the MERG. The information from this review will be implemented by updating the M&E Plan and supporting documents to improve system performance.

1. M&E System Performance Objective 1: Develop a National HIV/AIDS M&E Plan

1.1 HIV/AIDS M&E plan linked to national strategic plan and addresses its objectives

2. M&E System Performance Objective 2: Implementation of an M&E Plan

2.1 Milestones in national HIV/AIDS M&E plan reached

3. M&E System Performance Objective 3: Assessing and upgrading of M&E system capacity

3.1 Appropriate staffing levels maintained to effectively support M&E system

4. M&E System Performance Objective 4: Produce High Quality Data on a Timely Basis

4.1 % monthly reports arrive on time

5. M&E System Performance Objective 5: Communicate HIV/AIDS Information to Relevant Stakeholders and Facilitate the Use of Information among Stakeholders

5.1 Interagency and intra agency units share reports, review progress and communicate information to decision makers

7. Mechanism for updating plan

The M&E Plan will formally be reviewed on an annual basis by the Monitoring and Evaluation Resource Group (MERG). However, on-going assessments and suggestions for modifications may become evident during the course of a strategic planning year, requiring more immediate attention and adjustments of the framework

APPENDIX A: Logical Framework

Priority Area #1: PREVENTION

Narrative	Verifiable Indicators	Means of Verification	Risks & Assumptions
GOAL			
To reduce the transmission of new HIV infections	<ul style="list-style-type: none"> Percentage of men & women aged 15-24 who are HIV infected 	ANC/STI Surveillance	Collected every two years
	<ul style="list-style-type: none"> Percentage of CSW who are HIV infected 	CSW second generation surveillance (PLACE-like methodology)	2006/2007 survey intended to be repeated every two years.
	<ul style="list-style-type: none"> Percentage of MSM who are HIV infected 	MSM second generation surveillance (PLACE-like methodology)	2006/2007 survey intended to be repeated every two years. Success is dependent on trust with community.
PURPOSE			
To achieve universal access to prevention services, focusing on most-at-risk populations	<ul style="list-style-type: none"> Number of individuals reached through TCI disaggregated by vulnerable groups (e.g. youth, MSM, CSW, prisoners, etc.) 	Reported to M&E unit by MOH BCC unit on an annual basis	There are challenges associated with defining sub-populations and with double-counting
	<ul style="list-style-type: none"> Number of people trained to provide prevention services to persons most at risk 	Stakeholder reports	
OBJECTIVES			
P1. To increase quality of prevention services			2000, 2004 and every 3-4 years.
P2. To increase accurate information of ways to prevent HIV and dispel myths	<ul style="list-style-type: none"> % of young people (15-24) or at risk groups who correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions 	KABP survey	Assumes representativeness/generalizability at the general population level.
P3. To identify communities and populations most at-risk			

Narrative	Verifiable Indicators	Means of Verification	Risks & Assumptions
OBJECTIVES (continued)			
P4. To increase access to targeted, age-appropriate HIV prevention services for youth	<ul style="list-style-type: none"> • % of young adults, 15 to 19 years old, who have never had sex • % of young men & women aged 15-24 reporting condom use the last time they had sex with a non-regular partner 	KABP survey	2000, 2004 and every 3-4 years. Assumes representativeness/generalizability at the general population level.
P5. To strengthen prevention efforts for CSW and others engaging in transactional sex	<ul style="list-style-type: none"> • % of CSW reporting condom use the last time they had sex with a client 	CSW second generation surveillance (PLACE-like methodology)	2006/2007 survey intended to be repeated every two years.
P6. To strengthen prevention efforts for MSM	<ul style="list-style-type: none"> • % of MSM reporting using a condom the last time they had anal sex with a male partner 	MSM second generation surveillance (PLACE-like methodology)	2006/2007 survey intended to be repeated every two years. Success is dependent on trust with community.
P7. To strengthen prevention efforts for tourism workers	<ul style="list-style-type: none"> • Number of persons trained by client and service area 	Stakeholder reports	
P8. To strengthen prevention efforts for inmates in correctional facilities	<ul style="list-style-type: none"> • Number of persons trained by client and service area 	Stakeholder reports	
P9. To increase prevention interventions in the labour sector directed at reducing stigma & discrimination	<ul style="list-style-type: none"> • Number of persons trained by client and service area 	Stakeholder reports	
P10. To strengthen prevention efforts for persons within the uniformed services	<ul style="list-style-type: none"> • Number of persons trained by client and service area 	Stakeholder reports	
P11. To strengthen HFLE program in the education sector (early childhood to tertiary)	<ul style="list-style-type: none"> • % of young adults, 15 to 19 years old, who have never had sex 	KABP survey	2000, 2004 and every 3-4 years. Assumes representativeness/generalizability at the general population level.
P12. To strengthen the capacity of the sectors in the national response to conduct prevention interventions	<ul style="list-style-type: none"> • Number of persons trained by client and service area 	Stakeholder reports	
P13. To reduce transmission from PLWHA to their partners and secondary infections			
P14. To improve prevention interventions for drug abusers			

Narrative	Verifiable Indicators	Means of Verification	Risks & Assumptions
OBJECTIVES (continued)			
P15. To increase the use of mass media in prevention efforts	<ul style="list-style-type: none"> • % of young adults, 15 to 19 years old, who have never had sex • % of young men & women (15-24) reporting condom use the last time they had sex with a non-regular partner 	KABP survey	2000, 2004 and every 3-4 years. Assumes representativeness/generalizability at the general population level.
P16. To identify cultural influentials who can positively shift existing risky cultural norms	<ul style="list-style-type: none"> • Number of persons trained by client and service area 	Stakeholder reports	
P17. To strengthen prevention efforts for vulnerable adolescents	<ul style="list-style-type: none"> • % of young adults, 15 to 19 years old, who have never had sex 	KABP survey	2000, 2004 and every 3-4 years. Assumes representativeness/generalizability at the general population level.
PREVENTION ACTIVITIES			
<u>P1. To increase quality of prevention services</u>			
<p>1.1 Develop guidelines, standards and a training curriculum in quality of care (respect, confidentiality, communication style, etc.) with specific focus on meeting the needs of youth, PLWHA, MSM, CSW, people with disabilities, and recognizing gender differences</p> <p>1.1a Build youth-friendly services using Youth. Now model</p> <p>1.2 Train workers in quality of care across sectors including linkages to accreditation processes, e.g.:</p> <ul style="list-style-type: none"> • Health sector BCC specialists, outreach workers, etc. • Guidance Counselors • Effective/popular school teachers & coaches • Correctional facility resident nurses and pharmacists • Pharmacists <p>1.3 Conduct quality control monitoring of prevention service delivery</p>			
<u>P2. To increase public awareness of HIV prevention, sex and sexuality</u>			
<p>2.1 Implement public campaigns involving the general population e.g. schools, clubs, churches, etc.</p> <p>2.2 Recruit influential men (e.g. men on the corners) to lead, design and participate in interventions</p>			

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PREVENTION ACTIVITIES (continued)

P3. To identify communities and populations most at risk

- 3.1 Map locations of target populations using PLACE data
 - 3.2 Assess current coverage of prevention services related to targeted populations & set coverage targets
 - 3.3 Develop workgroup to regularly review surveillance data for targeted community efforts.
-

P4. To increase access to targeted, age-appropriate HIV prevention services for youth

- 4.1 Facilitate stakeholder consultation (administration, youth, parents, service providers, legal community) on adolescents accessing SRH information & services towards developing evidenced-based programmes and/or policy position.
 - 4.2 Update/develop policy and legislation to improve access to services and treatment (inclusive of VCT, contraception and disclosure etc.) without parental consent
 - 4.3 Identify best-practice holistic peer education strategies through formative research and program evaluation.
 - 4.4 Develop and implement a best-practice structured youth outreach, peer education and support programme. Consider partnering with existing non-HIV peer youth services.
 - 4.5 Expand out-of-clinic youth services (and ensure governance by service provision policy)
 - 4.6 Define and develop "Youth Safe Spaces" with age-, sexual orientation- and gender- specific activities
 - 4.7 Tailor messages and outreach for youth with disabilities
 - 4.8 Expand targeted interventions for youth in the Tourism Industry
 - 4.9 Include HIV prevention as part of the Mandatory Community Placement Programme for tertiary students
-

P5. To strengthen prevention efforts for commercial sex workers (CSW) and others engaging in transactional sex

- 5.1 Conduct Formative Research to better understand:
 - (1) Sexual behavior of entertainment workers (e.g. masseurs, water sports operators)
 - (2) Transactional sex practices
 - 5.2 Develop and implement interventions that focus on the gender issues that inform sex work to empower sex workers – male and female to make healthy choices
 - 5.3 Develop and implement interventions targeting entertainment workers through PLACE
 - 5.4 Identify best practice for peer education and scale up
 - 5.5 Improve skills to negotiate condom use with main partner
-

P6. To strengthen prevention efforts for Men who Have Sex with Men

- 6.1 Conduct participatory community-based research on social norms and access to social support within this population
 - 6.2 Review international best practices related to prevention, treatment, and care among MSM and make recommendations for adaptations in Jamaica
 - 6.3 Use/adapt existing interventions (e.g. PLACE) to reach MSM
 - 6.4 Identify influentials that can provide access to other MSM networks
 - 6.5 Increase access to prevention services
-

PREVENTION ACTIVITIES (continued)

P7. To strengthen prevention efforts for Tourism Workers

- 7.1 Conduct participatory community-based research on social norms and access to social support within this population
 - 7.2 Replicate successful models (e.g. Sandals) in other hotels
 - 7.3 Recruit “champions” in the hotel industry to address HIV/AIDS
-

P8. To strengthen prevention efforts for Inmates in Correctional Facilities

- 8.1 Review results and lessons learned of pilot project in Tower Street for implementation in other correctional facilities
 - 8.2 Develop integration and sustainability plan for efforts in correctional facilities
 - 8.3 Develop guidelines and reorientation training for persons employed in prisons
 - 8.4 Strengthen the functions of the Department of Corrections resident nurse to reach staff through risk assessment and counseling
-

P9. To increase prevention interventions in the labour sector

- 9.1 Identify leaders and other influentials to mobilize the sector to own and address HIV/AIDS issues at the workplace
 - 9.2 Equip sector with skills to establish sector wide prevention programmes for workers
-

P10. To strengthen prevention efforts for persons within the uniformed services

- 10.1 Establish condom outlets at sites where uniformed services are posted
 - 10.2 Develop peer education program at sites for persons in uniformed services
 - 10.3 Create supportive environment to reinforce practice of safer sex behaviours in this population
-

P11. To strengthen HFLE program in the education sector (early childhood to tertiary)

- 11.1 Complete revision of HFLE curriculum at all levels and implement comprehensive sector-wide programme
 - 11.2 Revise and implement the national HFLE policy (and HIV/AIDS policy), inclusive of materials development, mandated time-tabling, etc.
 - 11.3 Enforce the code of conduct of Guidance Counselors (teaching professionals) especially regarding breach of confidentiality
 - 11.4 Implementation of whole institution approach to teaching of HFLE
-

P12. To strengthen the capacity of the sectors in the national response to conduct prevention interventions

- 12.1 Introduction/expansion of courses at the tertiary level to equip a cadre of trained personnel to conduct prevention interventions in all sectors involved in the national response
 - 12.2 Documentation of in-service training conducted within sectors to be used to inform curriculum for professional courses
-

PREVENTION ACTIVITIES (continued)

P13. To reduce transmission from PLWHA to their partners and secondary infections

- 13.1 Train health workers in age and gender-specific motivational interviewing techniques for positive prevention
 - 13.2 Develop common messages for Positive Prevention including risks of secondary prevention
 - 13.3 Create and implement support groups for PLWHA
 - 13.4 Mobilize the community to provide leadership on this issue
-

P14. To improve prevention interventions for drug abusers

- 14.1 Develop and implement policy for most-at-risk drug abusers, involved in sex work
 - 14.2 Improve access to prevention services rehab process
-

P15. To increase the use of the mass media in prevention efforts

- 15.1 Expand media alliance with media managers
 - 15.2 Develop and air media campaign messages aimed at risk reduction and stigma reduction
-

P16. To identify cultural influentials who can positively shift existing risky cultural norms

- 16.1 Identify influentials in music, media, formal and informal community leaders and sports
 - 16.2 Develop strategy to assist in shifting adult entertainment from mainstream media
-

P17. To strengthen prevention efforts for vulnerable adolescents

- 17.1 Assess size of population of vulnerable groups of adolescents (e.g. disabled, street children, adolescent sex workers, etc.)
 - 17.2 Develop contextual and age appropriate interventions to reach this population
 - 17.3 Improve access to prevention services for vulnerable adolescents
-

Priority Area #2: TREATMENT, CARE & SUPPORT

Narrative	Verifiable Indicators	Means of Verification	Risks & Assumptions
GOAL			
	<ul style="list-style-type: none"> % of adults and children on ART who are still alive 12 months after initiation of antiretroviral therapy 	Treatment database from electronic medical records	Treatment database only collects data on public health clients and misses those seen by private providers
PURPOSE			
<p>To achieve universal access to high quality comprehensive treatment, care and support in an environment that is non-discriminatory and supports adherence</p>	<ul style="list-style-type: none"> % of most-at-risk populations (youth, MSM, CSW (who received HIV testing in the last 12 months & know the results) 	<ul style="list-style-type: none"> MSM & CSW second generation surveillance (PLACE-like methodology) Healthy Lifestyles Survey KABP 	<p>2006/2007 surveys intended to be repeated every two to three years.</p> <p>Surveys are dependent on external funding.</p>
	<ul style="list-style-type: none"> % of women, men & children with advanced HIV infection who are receiving antiretroviral combination therapy according to national guidelines 	Monthly treatment site reports from program coordinators to parish medical officers and technical directors	<p>Regions are clear on definitions and instructions on completion of monthly reporting forms.</p> <p>Timeliness is a problem. There are delays at each step in the data flow. Also, data only available for public health clients, not private.</p>
OBJECTIVES			
T1. To increase access to HIV testing among priority populations	<ul style="list-style-type: none"> % of most-at-risk populations (youth, MSM, CSW (who received HIV testing in the last 12 months & know the results) 	<ul style="list-style-type: none"> MSM & CSW second generation surveillance (PLACE-like methodology) Healthy Lifestyles Survey KABP 	<p>2006/2007 surveys intended to be repeated every two to three years.</p> <p>Surveys are dependent on external funding.</p>

Narrative	Verifiable Indicators	Means of Verification	Risks & Assumptions
OBJECTIVES (continued)			
T2. To prevent Mother to Child Transmission of HIV	<ul style="list-style-type: none"> % of infants born to HIV-infected mothers [who are HIV infected] 	Regional HIV/AIDS Monthly Report Form (RHAMR)	Regions need clarified instructions and definitions
T3. To improve access to and quality of ARV treatment	<ul style="list-style-type: none"> % of women, men & children with advanced HIV infection who are receiving antiretroviral combination therapy according to national guidelines 	Monthly treatment site reports from program coordinators to parish medical officers and technical directors	Regions are clear on definitions and instructions on completion of monthly reporting forms. Timeliness is a problem. There are delays at each step in the data flow. Also, data only available for public health clients, not private.
T4. To increase adherence to treatment and care	<ul style="list-style-type: none"> % of PLWHA on ARV reporting at least 90% adherence by pill count 	National Health Fund Database Adherence counselor/social worker reports	NHF Database has some issues Monthly reports
T5. To Improve care and support for Orphans and Vulnerable Children (OVC)	<ul style="list-style-type: none"> Ratio of current school attendance among orphans to non-orphans, aged 10-14 	MICS is done every 5 years by UNICEF.	First one was done in 2005-2006. STATIN does the analysis. MOH is a partner in the working group.
T6. To improve access and use of Home Based Care		Quarterly regional technical reports by the regional HIV coordinator from stakeholder reports and social workers.	Reporting process is new. There are difficulties defining home based care and difficulties with coordination among various players.
T7. To improve infection control and access to Post-Exposure Prophylaxis (PEP) for accidentally exposed Health Care Workers		Quarterly regional technical reports by the Regional HIV Coordinators Quarterly Regional Surveillance Officer reports	
T8. To strengthen prevention efforts for PLWHA	<ul style="list-style-type: none"> Number of persons trained to provide treatment services by client and service area 	Stakeholder reports	
T9. To improve the management of tuberculosis, especially in the HIV infected	<ul style="list-style-type: none"> Proportion of confirmed TB cases tested for HIV % of HIV positive TB patients who began or continued ARV during TB treatment 	Quarterly Regional Surveillance Officer reports Quarterly NPHL Report	

Narrative	Verifiable Indicators	Means of Verification	Risks & Assumptions
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OBJECTIVES (continued)

T10. To strengthen the management of Sexually Transmitted Infections, including syphilis	<ul style="list-style-type: none"> • Incidence of congenital syphilis • % of persons with STIs managed appropriately as per Syndromic Management protocol 	Case reporting Health Facility Assessment	Not yet conducted
T11. To improve the diagnostic capacity of the laboratory services			
T12. To strengthen and institutionalize the training programme	<ul style="list-style-type: none"> • Number of persons trained to provide treatment services by client and service area 	Stakeholder reports	

TREATMENT, CARE & SUPPORT ACTIVITIES

T1. To increase access to HIV testing among priority populations

- 1.1 Scale up PITC to all users of primary, secondary and tertiary services (especially for persons between the ages 10 to 60 years).
- 1.2 Test all persons who are being treated for STIs
- 1.3 Test all persons who are being treated for TB
- 1.4 Assure quality counseling and referrals and provide training in PITC
- 1.5 Conduct Formative Research to better understand the real and perceived barriers to testing and perception of risk
- 1.6 Conduct Media Campaign to increase awareness regarding the importance of testing and perception of risk
- 1.7 Build capacity in NGOs to capably address barriers to HIV testing
- 1.8 Reach vulnerable populations through peer approaches and their networks and events
- 1.9 Conduct targeted outreach of male youths by partnering with male-focused organizations, and going to heavily populated male events, use champions and role model men
- 1.10 Conduct VCT at sites where young spend time (e.g. Sports venues, Bashy Bus, Adolescents centre where young people do school work, etc.)
- 1.11 Increase number of confidential areas at testing sites to facilitate counseling and privacy

TREATMENT, CARE & SUPPORT ACTIVITIES (continued)

T2. To prevent Mother to Child Transmission of HIV

- 2.1 Retrain Public Health Nurses and Midwives in updated protocol PMTCT+ on an annual basis
 - 2.2 Screen all HIV positive pregnant women with CD4 counts
 - 2.3 Ensure all women testing positive receive appropriate antiretroviral therapy for prevention of mother to child transmission in accordance with revised PMTCT+ guidance
 - 2.4 Identify mechanisms to reach at-home births (e.g. midwife training)
 - 2.5 Ensure rapid testing for women arriving at maternity ward with unknown status
 - 2.6 Conduct appropriate follow-up of mother-baby pairs
 - 2.7 Ensure all points of service delivery must have starter packs of ARV.
 - 2.8 Increase the number of sites offering the HIV testing service
 - 2.9 Use Child Protection Act to assure testing and treatment of mother
 - 2.10 Engage fathers in the delivery of the PMTCT programme by offering testing and providing HIV related information
 - 2.11 Provide universal access to long term Family Planning Methods
 - 2.12 Improve information sharing (M&E) between primary, secondary and national levels
-

T3. To improve access to and quality of ARV treatment

- 3.1 Increase the number of sites at which treatment is available by involving all Primary Care Staff in treatment and maintaining the current Treatment Centres as Specialist referral sites
 - 3.2 Retrain clinic staff in updated HIV Management Protocol on an annual basis
 - 3.3 Improve access to CD4 and viral load testing
 - 3.4 Conduct resistance testing
 - 3.5 Conduct appropriate follow-up of patients
 - 3.6 Make existing and new sites 'Youth friendly' by hiring younger people, or involving them as volunteers, and providing holistic, non-judgmental support.
 - 3.7 Identify best-practices for engaging men in treatment. (E.g. Examine the male health seeking behaviour and address the findings)
 - 3.8 Review "User Fee Policies" to ensure that patients' fees are set appropriately and that treatment is not denied. Assess how User Fee Policies affect access to treatment.
 - 3.9 Conduct quality assurance audits at all levels of service
 - 3.10 Develop and implement an information tracking system that facilitates effective management of appointments and medication
 - 3.11 Develop mechanism to integrate pharmacy outlets for ARV with treatment centers
 - 3.12 Improve supply management structure for ARV
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TREATMENT, CARE & SUPPORT ACTIVITIES (continued)

T4. To increase adherence to treatment and care

- 4.1 Enrolling persons on antiretrovirals with NHF, will allow them a further discounted access to medication
 - 4.2 Review TOR of adherence counselors to include counseling for HIV testing as well as adherence counseling on a wider scale, in the hospitals, etc.
 - 4.3 Development of a structured adherence protocol for pre-ARV treatment
 - 4.4 Strengthen adherence programme by involvement of all members of the treatment team
 - 4.5 Ensure provision of nutritional advice and support by all members of the treatment team
 - 4.6 Provide training in adherence to all members of the treatment team
 - 4.7 Development of treatment support groups
 - 4.8 Simplify regime by increased availability of fixed combination drugs
 - 4.9 Collaborate with NGOs and other relevant agencies that can provide financial and social support (for meals, transportation, school fees) and income generating assistance to PLWHA
 - 4.10 Develop linkages and referral mechanisms to community support
 - 4.11 Utilize non-traditional health care workers to ensure follow-up with known PLWHA
 - 4.12 Develop and distribute user-friendly material for PLWHA that describes treatment (medication, nutrition), and adherence
-

T5. To improve care and support for Orphans and Vulnerable Children (OVC)

- 5.1 Identify a specific agency (CDA?) to be charged with assuring that children are on medication and receive appropriate care
 - 5.2 Employ a Children's Officer to work from the Ministry of Health to liaise with relevant agencies, develop and implement mechanisms to ensure the follow-up of OVC
 - 5.3 Address issues of vulnerability taking into consideration the following specific groups:
 - Orphans in Homes
 - Street Children
 - Young girls who head households
 - Boys who have to hustle
 - Children with disabilities
-

T6. To improve access and use of Home Based Care

- 6.1 Develop a registry of home based caregivers and agencies to provide these services and disseminate this information
 - 6.2 Provide training to care givers in Home Based Care
 - 6.3 Involve family members and other support groups (e.g. Churches, etc.) in the training of home based care
-

T7. To improve infection control and access to Post Exposure Prophylaxis for accidentally exposed Health Care Workers

- 7.1 Implementation of an alternative technology for medical waste (including sharps) management
 - 7.2 Update and reprint the infection control manual and distribute widely
 - 7.3 Training of all levels of health care workers in the management of post-exposure prophylaxis
-

TREATMENT, CARE & SUPPORT ACTIVITIES (continued)

T8. To strengthen prevention efforts for PLWHA

- 8.1 Integrate expected roles and responsibilities of PLWHA into existing HIV/AIDS Policy
 - 8.2 Develop standardized messages geared towards encouraging responsible sexual behaviour among PLWHA
 - 8.3 Develop and strengthen support groups and provide intervention counselling for PLWHA attending treatment sites
 - 8.4 Train available adherence counselors in Positive Prevention Methodologies.
 - 8.5 Conduct trainings in Positive prevention for PLWHA
-

T9. To improve the management of Tuberculosis especially in the HIV infected

- 9.1 Strengthen linkages between TB and HIV programmes.
 - 9.2 Screen all HIV infected persons for TB as well as ensure the availability of facilities for early diagnosis.
 - 9.3 Ensure the availability of anti-TB drugs
 - 9.4 Conduct training for HCW in the management of TB and TB/HIV
 - 9.5 Improve the follow-up of TB patients to ensure completion of course of medication
 - 9.6 Improve the capacity of the laboratory to conduct diagnostic tests for TB and resistance testing.
-

T10. To strengthen the management of Sexually Transmitted Infections including Syphilis

- 10.1 Conduct trainings in the management of STIs including Syphilis
 - 10.2 Improve the capacity of the laboratory to conduct testing to determine aetiological agents
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T11. To improve the diagnostic capacity of the laboratory services

- 11.1 Expand the capacity of the laboratory services to deal with the increased numbers of persons being tested
 - 11.2 Improve the management structure of the NPHL
 - 11.3 Improve the capacity of the laboratories (in the regions also) to diagnose TB, STIs and opportunistic infections.
 - 11.4 Expand the lab capacity to include resistance testing for Anti TB and HIV drugs.
 - 11.5 Improve the capacity of the laboratory to carry out CD4, Viral Loads and other supportive investigation
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T12. To strengthen and institutionalize the training programme

- 12.1 In collaboration with CHART to develop standard short courses for HIV case managements, PMTCT, Adherence, Infection Control and Counselling for HCW.
 - 12.2 Conduct trainings for HCW
 - 12.3 Regions to duplicate trainings to ensure dissemination of information to all relevant staff
 - 12.4 Conduct audits to ensure standard and quality of care.
-

Priority Area #3: ENABLING ENVIRONMENT & HUMAN RIGHTS

Narrative	Verifiable Indicators	Means of Verification	Risks & Assumptions
GOAL			
To protect fundamental human rights and empower the Jamaican people to make healthy choices	<ul style="list-style-type: none"> Percentage of people 15-49 years expressing accepting attitudes towards people with HIV/AIDS 	KABP survey	2000, 2004 and every 3-4 years. Assumes representativeness/generalizability at the general population level.
PURPOSE			
To decrease stigma and discrimination toward people with HIV/AIDS	<ul style="list-style-type: none"> Number and percent of reported cases of HIV-related discrimination receiving redress by setting 	Reports from MOE, Red Cross, Ministry of Labour, and JAS to JN+ Additional sources might include UNHCR, UNAIDS, UNICEF, but are not HIV specific Stigma & discrimination working group	Would need to do a baseline court survey - affordability issues. Need to define redress (greater technical clarity) and incorporate definition into reporting system Need to establish coordinated mechanism and get buy in from partners.
OBJECTIVES			
E1. To systematically identify and report acts of discrimination	<ul style="list-style-type: none"> Number and percent of reported cases of HIV-related discrimination receiving redress by setting 	JN+ stigma database collects this information and reports in quarterly to the NAC	Database is still under development
E2. To improve public awareness of HIV and AIDS	<ul style="list-style-type: none"> Number of persons trained by client and service area 	Stakeholder reports	
E3. To strengthen community advocacy against stigma and discrimination			
E4. To reduce stigma in all sectors	<ul style="list-style-type: none"> Percentage of large enterprises/companies that have HIV/AIDS workplace policies and programs 	Ministry of Labour conducts a workplace survey every 2-3 years. Last one was in 2005.	

Narrative	Verifiable Indicators	Means of Verification	Risks & Assumptions
E5. To reduce stigma and discrimination in the health sector			<p>Would need to do a baseline court survey - affordability issues.</p> <p>Need to define redress (greater technical clarity) and incorporate definition into reporting system</p> <p>Need to establish coordinated mechanism and get buy in from partners.</p>
E6. To empower youth to address stigma and discrimination	<ul style="list-style-type: none"> Number of policy makers attending sensitization workshops on HIV/AIDS/STI 		

OBJECTIVES

E7. To empower PLWHA in the context of reducing stigma and discrimination and seeking treatment and care			
E8. To advocate for legislation that protects human rights	<ul style="list-style-type: none"> Number of policy makers attending sensitization workshops on HIV/AIDS 		
E9. To advocate for non-discrimination among management and employees of the insurance sub-sector			

ENABLING ENVIRONMENTS & HUMAN RIGHTS ACTIVITIES

E1. To systematically identify and report acts of discrimination

- 1.1 Assemble a multi-sector working group to define 'Discrimination' & identify specific examples including unequal access for people with disabilities.
- 1.2 Develop a common Discrimination Reporting tool for civil society and all sectors to report discrimination
- 1.3 Develop & maintain a system of data collection, data maintenance (database) and analysis of reports of stigma, discrimination and response
- 1.4 Establish a system with office of Public Defenders to act upon data on behalf of persons who have been discriminated against
- 1.5 Develop and implement a dissemination strategy/information campaign to civil society and all sectors so they utilize the Discrimination Reporting mechanism

ENABLING ENVIRONMENTS & HUMAN RIGHTS ACTIVITIES (continued)

E.2 To improve public awareness of HIV and AIDS

- 2.1 Develop and implement anti stigma mass media campaign with supporting public relations campaign with gender-specific, geographic-specific and target-group-specific messages
 - 2.2 Develop messages that reinforce that HIV is important to address because of the economic impact, potential to spread and for protection of human rights.
 - 2.3 Use cell phones as avenues to reach young people in terms of HIV messages
 - 2.4 Use drama and other cultural approaches to create awareness of gender specific issues
-

E3. To strengthen Community Advocacy against Stigma and Discrimination

- 3.1 Conduct community-specific research to identify the extent that PLWHA and families can challenge community level S&D
 - 3.2 Facilitate community consultations in urban and rural parishes for development of support mechanisms for PLWHA and their families. Include a broad array of organizations including churches.
-

E4. To reduce stigma in all sectors

- 4.1 Expand development and implementation of workplace policies and programmes including action for breaches.
 - 4.2 Implement disciplinary measures when Policy is violated
 - 4.3 Promote existing Education Policy and Child Care Act in private schools and monitor activities which support or contravene principles enshrined in the Act.
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E5. To reduce stigma and discrimination in the health sector

- 5.1 Develop and implement a health care policy to ensure adherence to a strict protocol for caregivers and other HCW when working with PLHIV, including privacy and confidentiality and a mechanism for recourse and sanctions for breaches of policy.
 - 5.2 Develop a comprehensive S & D programme which incorporates training for quality of care for health workers.
-

E6. To empower Youth to address Stigma and Discrimination

- 6.1 Use Sphere of influence Model (reference to JASTYLE)
 - 6.2 Infuse S&D messages into school curriculum such as the Safe Schools Programme
 - 6.3 Utilize NYS Health Promotion Facilitators trained by MOH to undertake targeted interventions in the communities.
 - 6.4 Develop programmes for young persons to interact with and show care and support for PLWHA e.g. Junior PAAs
-

ENABLING ENVIRONMENTS & HUMAN RIGHTS ACTIVITIES (continued)

E7. To empower PLWHA in the context of reducing stigma and discrimination and seeking treatment and care

7.1 Conduct research to understand social and economic needs of PLWHA and how best to engage them in services

7.2 Provide PLWHA with training and support in: (1) Life and communication skills (2) Positive prevention (3) anti stigma and discrimination interventions (4) work place implementation and treatment compliance and adherence (5) Skills to achieve economic independence (6) Psycho-social support to address perceived or internal stigma and to enhance self-esteem

7.3 Provide shelter and other facilities for persons who are negatively treated when they disclose their status e.g. Safe House

7.4 Adapt protocol and training for Contact Investigators to: (1) Address and support issues of disclosure to PLWHA partners (2) Refer PLWHA to the existing support and advisory boards and encourage their participation

E8. To advocate for Legislation that protects human rights

8.1 Submit recommendation to Cabinet for support of anti discrimination laws to reduce human rights violations

8.2 Provide legal assistance to PLWHA (*pro bono*)

8.3 Develop and Implement safeguards against sexual violence and exploitation of girls

8.4 Identify leaders/change champion for law reform including repeal of the buggery law (re human rights) and conduct education & dialogue on the issue

8.5 Assess/examine policy/legislative options regarding regulations of CSW.

8.6 Amend education act to change HIV as a communicable disease and include private institutions

8.7 Enhance lobbying and advocacy for OVC in institutions: social integration etc.

E.9 To advocate for non discrimination among management and employees of the Insurance sub sector

9.1 To establish and implement interventions targeted to management and employees in the Insurance sub sector focused on negotiations, advocacy, public education and training in regards to the 10 workplace principles

Priority Area #4: EMPOWERMENT & GOVERNANCE

Narrative	Verifiable Indicators	Means of Verification	Risks & Assumptions
GOAL			
To achieve a sustained, effective multi-sectoral infrastructure and commitment to support the National Response to HIV and AIDS	<ul style="list-style-type: none"> National Composite Index 	Country Assessment done every 2 years by the M&E Unit	Adapted from UNGASS tool
PURPOSE			
Integration of HIV programs into existing human and social development programs	<ul style="list-style-type: none"> National Composite Index 	Country Assessment done every 2 years by the M&E Unit	Adapted from UNGASS tool
OBJECTIVES			
G.1 To build capacity and commitment of health sector to recognize their role and provide high-quality services for all people	<ul style="list-style-type: none"> Number of persons trained by client and service area 	Stakeholder reports	
G.2 To build capacity and commitment of other sectors			
G.3 To develop one monitoring and evaluation framework	<ul style="list-style-type: none"> Number of individuals trained in strategic information (M&E and/or surveillance and/or HMIS) 	Reported by stakeholders to M&E unit annually for PEPFAR reporting	Does not assess quality of training or TA
G.4 To improve procurement and financial management systems			
G.5 To implement a sustainability plan			

Narrative	Verifiable Indicators	Means of Verification	Risks & Assumptions
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OBJECTIVES (continued)

G.6 To assure multi-sectoral commitment to National Strategic Plan	<ul style="list-style-type: none"> Number of NGOs providing HIV/AIDS prevention, treatment, care and support services according to national guidelines/ standards 		
	<ul style="list-style-type: none"> Percentage of schools with teachers who have been trained in life-skills based HIV/AIDS education and who taught it during the last academic year 	Educational program review conducted by Ministry of Education every 2 years	
G.7 To assure strong governance and accountability	<ul style="list-style-type: none"> Number of policy makers attending sensitization workshops on HIV/AIDS 		

EMPOWERMENT & GOVERNANCE ACTIVITIES

G1. To build capacity and commitment of health sector to recognize their role and provide high-quality services for all people

- 1.1 Assess Human Resource needs as part of a sustainability plan and implement chosen recommendations
- 1.2 Strengthen staff knowledge and skills through Pre-service Training, CHART and other sensitisation and training
- 1.3 Develop a clinic-based information system
- 1.4 Implement a Laboratory Information System
- 1.5 Ensure participation of health care workers in the review of health data and decision-making processes

G2. To build capacity and commitment of other sectors to recognize their role in the response

- 2.1 Strengthen partner knowledge and skills through CHART and other sensitisation and training
- 2.2 Address barriers and improve implementation of a family life education in schools that adequately addresses sex, sexuality and health
- 2.3 Provide individualized technical assistance to selected NGOs (e.g., NAC, JN+, etc.) to build their capacity in accountability, quality control, M & E
- 2.4 Develop an NGO forum
- 2.5 Conduct outreach and training to civil society to understand policy processes, advocacy, and their role
- 2.6 Institutionalize mechanisms for participation of civil society (MSM, CSW, PLWHA) in programme design, monitoring and evaluation
- 2.7 Develop a youth-board for input on planning, implementation and evaluation
- 2.8 Train young PLWHA as peer educators and outreach officers in schools, etc.
- 2.9 Provide capacity building training workshops for community youth and youth organizations in life & leadership skills

EMPOWERMENT & GOVERNANCE ACTIVITIES (continued)

G3. To develop one monitoring and evaluation framework

- 3.1 Identify priority indicators and sources for use by all sectors
 - 3.2 Assist key partners in development and implementation of their M & E systems
 - 3.3 Train stakeholders in data collection and surveillance methods for programme monitoring
 - 3.4 Implement the HIV/AIDS Tracking System (HATS)
 - 3.5 Monitor and Evaluate the National Strategic Plan
-

G4. To improve procurement and financial management systems

- 4.1 Align the GOJ procurement process to that of the International Donor Agencies
 - 4.2 Allow for special provisions in the procurement process for the HIV/AIDS Programme
-

G5. To implement a sustainability plan

- 5.1 Institutionalize the positions of the National HIV/AIDS programme posts in the present government cadre
 - 5.2 Include as a separate budget line item for HIV/AIDS in the recurrent budget
 - 5.3 Provide capacity building, training, and development of systems and guidelines across partners
 - 5.4 Develop systems to strengthen integrity/transparency of resource allocation between intervention alternatives
 - 5.5 Develop incentive scheme for ongoing service delivery after training
 - 5.6 Include PLWHA and other vulnerable populations in the implementation of the plan
-

G6. To assure multi-sectoral commitment to National Strategic Plan

- 6.1 Establish mechanisms for communication, coordination, implementation and operation at the national and regional levels
 - 6.2 Identify specific roles and responsibilities for each sector
 - 6.3 Develop sector-specific work plans
 - 6.4 Develop an NGO forum to share best-practices/lessons learned and to coordinate activities
-

G7. To assure strong governance and accountability

- 7.1 Establish a multi-sectoral working group to consider structure for One Authority (mechanism for coordination and accountability across all sectors)
 - 7.2 Move forward on creation of One Authority once roadmap is agreed upon
 - 7.3 Establish mechanisms for communication and coordination across sectors to minimize duplication of efforts
 - 7.4 Implement the One Authority entity based on the selected structure/ format
 - 7.5 Monitor and evaluate the performance of the One Authority entity
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APPENDIX B: Jamaica National Strategic Plan, Core Indicators

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #1: PREVENTION										
Goal	UNGASS, Global Fund, CARICOM	UN-GE 15. Percentage of men & women aged 15 to 24 that are HIV infected	ANC/STI Surveillance Report	Annually	National HIV Surveillance Officer	1.2% 1.5%	2002 2005	≤1.5%	2009 and 2011	Yes, but HATS needs full implementation
Goal	UNGASS, USAID, World Bank	UN-C/LPE 9.a. Percentage of CSWs who are HIV infected	CSW Second Generation Surveillance	2005 and every 2 years	NAP M&E Unit	9%	2005	7% <7%	2010 2012	Yes
Goal	UNGASS, USAID	UN-C/LPE 9.b. Percentage of MSM who are HIV infected	MSM Second Generation Surveillance	2006 and every 2 yrs	NAP M&E Unit	TBD	2007	< 25%	2011	Data collection in progress
Purpose	Global Fund, USAID	USJ 9. Number of individuals reached through prevention activities disaggregated by vulnerable groups (e.g. youth, MSM, CSW, prisoners, etc.)	Stakeholder & Regional Technical reports	Monthly	BCC & HIV Coordinators	CSW: 3480 MSM: 4800 STI clinic attendees: 40,000 Inmates: TBD		CSW: 8500 MSM: 8,000 6,600 STI clinic attendees: 225,000 Inmates: 3000 (all cumulative)	2012	Yes - being implemented
Purpose P7-P10, P12, P16		Number of persons trained to provide services by client and service area	Stakeholder & Regional Technical reports	Monthly	BCC & HIV Coordinators					
P2	UNGASS, Global Fund, CARICOM, CIMT	UN-GE 10. Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	KABP	2000, 2004 and every 3-4 years	NAP M&E Unit	M: 29.6% F: 33.4% M: 36.2% F: 40.0%	2000 2004	M: 60% F: 60%	2011	Yes
P4, P11, P15, P17		Percentage of young adults, 15 to 19 years old, who have never had sex	KABP	2004 and every 3-4 years	MOH	M: 27.6% F: 50.5%	2004	M: 35% F: 55%	2011	Yes

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #1: PREVENTION										
P4, P15 (15-24 yrs)	UNGASS, Global Fund, World Bank, CIMT	% of young women and men aged 15-24 reporting the use of a condom the last time they had sex with a non-regular partner	KABP	2004 and every 3-4 years	NAP M&E Unit	Ages 15-49				Yes
						M: 77.3% F: 71.7%	2000	M: 80% F: 75%	2011	
P5	UNGASS, Global Fund, USAID, World Bank, CIMT	UN-C/LPE 4. Percentage of CSW reporting using a condom at last sex act with client	CSW survey	2005 & every 2-3 yr	NAP M&E Unit	75% 92%	2003 2005	>90%	2011	Yes
P6	UNGASS, Global Fund	UN-C/LPE 5. Percentage of MSM reporting using a condom the last time they had anal sex with a male partner	MSM survey	2006 & every 2-3 years	NAP M&E Unit	TBD	2003	10% increase 20% over baseline	2010 2012	Yes
PRIORITY AREA #2: TREATMENT, CARE & SUPPORT										
GOAL	UNGASS, CARICOM	UN-GE 16. Percentage of adults & children with HIV still alive 12 months after initiation of ART	Treatment database from EMR	Monthly	Treatment coordinator	75%	2006	90%	2012	In development, 2004 estimate based on UNGASS calculations
PURPOSE, T1	UNGASS	UN-C/LP 3. Percentage of most-at-risk populations (MSM, CSW) who received HIV testing in the last 12 months and who know the results	Surveys (MSM, CSW, Healthy Lifestyles)	every 2 yr	NAP M&E Unit	CSW: 43% MSM TBD	2005	CSW 50%	2012	Yes
PURPOSE, T3	UNGASS, Global Fund	GF 23. Percentage of men, women & children with advanced HIV receiving antiretroviral combination therapy according to national guidelines	Treatment site reports	Monthly	Regional Surveillance Officers/ Treatment coordinator	3000	April 2007	Adult: 4,800 Children: 200 by 2008 then 500 per year	2012	Yes

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #2: TREATMENT, CARE & SUPPORT										
T2	UNGASS, Global Fund, GoJ, USAID	UN-GE 17. Percentage of infants born to HIV-infected mothers [who are HIV-infected]	Regional HIV/AIDS Monthly Report (RHAMR)	Monthly	Regional Surveillance Officers & HIV Coordinators	25% 12% 10%	2000 2005 2006	< 10% < 5%	2007 2012	Regional Report; PMTCT database needs full implementation
T4		Percentage of PLWHA on ARV reporting at least 90% adherence by pill count	National Health Fund Database Adherence counselor/ social worker reports	Monthly	Adherence counselors, social workers, HIV Coordinators	75%	2006	80%	2012	Yes
T5	UNGASS	UN-GE 14. Ratio of current school attendance among orphans to that among non-orphans, aged 10-14	MICS	every 5 yrs (Nov-Mar 2005-06)	UNICEF	0.99	2005	Maintain >0.9	2012	Yes
T8, T12		Number of persons trained to provide services by client and service area	Stakeholder & Regional Technical reports	Monthly	BCC & HIV Coordinators					*repeat
T9		Proportion of confirmed TB cases tested for HIV	Regional Surveillance Officer Reports NPHL Reports	Quarterly Quarterly	TB Surveillance Officer NPHL	85%	2005	>90%	2012	Yes
T9		Percentage of HIV positive TB patients who began or continued ARV during TB treatment	Regional Surveillance Officer Reports	Quarterly	Regional Surveillance Officers	TBD				Yes

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #2: TREATMENT, CARE & SUPPORT										
T10		Incidence of congenital syphilis	Case reporting	Annually	STI Officer	26.2 per 100,000 births	2004	15 per 100,000 births	2012	Yes
PRIORITY AREA #3: ENABLING ENVIRONMENT & HUMAN RIGHTS										
GOAL	Global Fund, CIMT	GF 42. Percentage of people 15-49 yrs expressing accepting attitudes towards people with HIV/AIDS	KABP	2004 and every 3-4 years	NAP M&E Unit	M: 8.7% F: 93%	2004	25%	2011	Yes
PURPOSE, E5		Number and percent of reported cases of HIV-related discrimination receiving redress by setting	MOE, Red Cross, Ministry of Labour, JAS	Quarterly	Stigma & discrimination working group	25%	2006	75%	2012	Needs to be refined
E2		Number of persons trained to provide services by client and service area	Stakeholder & Regional Technical reports	Monthly	BCC & HIV Coordinators					*repeat
E4	UNGASS, CIMT	UN-GE 4. Percentage of large enterprises/ companies that have HIV/AIDS workplace policies and programs	Workplace Survey (25 private, 5 public)	Nov 2005 & every 2-3 years	Ministry of Labour/M&E Unit	10%	2005	30%	2012	Yes
		Number of local organizations provided with technical assistance for HIV-related policy development	Stakeholder report	Monthly	Policy working group	55	2006	110	2012	Yes
E8		Number of policy makers attending sensitization workshops on HIV/AIDS/STI				TBD		100% increase over baseline	2012	

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
EMPOWERMENT & GOVERNANCE										
GOAL, PURPOSE	UNGASS	UN-GE 2. National Composite Policy Index	Country assessment	Every 2 years	NAP M&E Unit					UNGASS tool adapted
G1		<i>Number of persons trained to provide services by client and service area</i>	<i>Stakeholder & Regional Technical reports</i>	<i>Monthly</i>	<i>BCC & HIV Coordinators</i>					<i>*repeat</i>
G3	PEPFAR	PEP 4.9. Number of individuals trained in strategic information (M&E and/or surveillance and/or HMIS)	Stakeholder PEPFAR Reports: MOH M&E Unit, IISPEC, MEASURE	annually	NAP M&E Unit	80	2006	Approx. 100/year i.e. 450 by 2012	2012	Yes
G6		Percent of NGOs providing HIV/AIDS prevention, treatment, care and support services according to national guidelines/standards	Stakeholder reports	Monthly	NAP M&E Unit/ Prevention Coordinator	TBD				Yes
G6	UNGASS	UN-GE 3. Percentage of schools with teachers who have been trained in the revised life-skills based HIV/AIDS education and who taught it during the last academic year	Educational program review	Every 2 years	Ministry of Education, focal point	5%	2006	80%	2012	Revised HFLE curriculum piloted in 24 schools in 2006.
G7		Number of policy makers attending sensitization workshops on HIV/AIDS/STI	Stakeholder reports	Monthly	Policy Coordinator	TBD				Yes

APPENDIX C: Complete Indicator Matrix

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #1: PREVENTION										
IMPACT										
Goal	UNGASS, Global Fund, CARICOM	UN-GE 15. Percentage of men & women aged 15 to 24 that are HIV infected	ANC/STI Surveillance Report	Annually	National HIV Surveillance Officer	1.2% 1.5%	2002 2005	≤1.5%	2009 and 2011	Yes, but HATS needs full implementation
Goal	UNGASS, USAID, World Bank	UN-C/LPE 9.a. Percentage of CSWs who are HIV infected	CSW Second Generation Surveillance	2005 and every 2 years	NAP M&E Unit	9%	2005	7% <7%	2010 2012	Yes
Goal	UNGASS, USAID	UN-C/LPE 9.b. Percentage of MSM who are HIV infected	MSM Second Generation Surveillance	2006 and every 2 yrs	NAP M&E Unit	TBD	2007	< 25%	2011	Data collection in progress
	World Bank	WB 1. Syphilis seroprevalence among ANC attendees 15 to 24 yrs	Epi MCSR	Monthly	MOH Surveillance Unit			Decrease 25%	2008	Surveillance Officer receives reports
	World Bank, CARICOM, GoJ	WB 2a. HIV prevalence among ANC attendees 15-24 years	ANC Sentinel Surveillance Report ¹	Biennially	National HIV Surveillance Officer					Yes
	World Bank	WB 2.c. HIV Prevalence among Army recruits	Army records & Surveillance report	Aggregate received quarterly	National HIV Surveillance Officer			Maintain at <1%		Yes
	World Bank, CARICOM	WB 2.d. HIV prevalence among 15-49 year olds in Kingston	ANC Sentinel Surveillance Report ¹	Biennially	National HIV Surveillance Officer					Yes
	CARICOM	CAR 1. Prevalence of HIV among STI clients	STI Sentinel Surveillance Report ¹	Biennially	National HIV Surveillance Officer			< 4%	2006	Yes
	CARICOM	CAR 2. AIDS Case rate	HATS database updates	ongoing	National Surveillance Officer			Below 1.5%	2010	Yes; need to fully implement HATS

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #1: PREVENTION										
OUTCOME										
P4, P15 (15-24 yrs)	UNGASS, Global Fund, World Bank, CIMT	GF4. % of people by sex and age groups who reported condom use at last intercourse with non-regular partner	KABP	2004 and every 3-4 years	NAP M&E Unit	Ages 15-49				Yes
						M: 77.3% F: 71.7%	2000	M: 80% F: 75%	2011	
P5	UNGASS, Global Fund, USAID, World Bank, CIMT	UN-C/LPE 4. Percentage of CSW reporting using a condom at last sex act with client	CSW survey	2005 & every 2-3 yr	NAP M&E Unit	75%	2003	95%	2011	Yes
						84.3%	2005			
P6	UNGASS, Global Fund	UN-C/LPE 5. Percentage of MSM reporting using a condom the last time they had anal sex with a male partner	MSM survey	2006 & every 2-3 years	NAP M&E Unit	38%	2003	60% then increase by 10% over baseline	2012	Yes
P2	UNGASS, Global Fund, CARICOM, CIMT	UN-GE 10. Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	KABP	2000, 2004 and every 3-4 years	NAP M&E Unit	M: 29.6% F: 33.4%	2000	M: 60% F: 60%	2011	Yes
						M: 36.2% F: 40.0%	2004			
P4, P11, P15, P17		Percentage of young adults, 15 to 19 years old, who have never had sex	KABP	2004 and every 3-4 years	MOH	M: 27.6% F: 50.5%	2004	M: 35% F: 55%	2011	Yes
	UNGASS, CIMT	UN-GE 9. Percentage of transfused blood units screened for HIV	Nat'l Blood Transfusion Service (NBTS) records	Annually	NBTS & Director-NPHL	100% 100%	2004 2005	100%		Yes
	UNGASS, World Bank, CIMT	UN-GE 11. Female and male median age at first sex	KABP	2004 and every 3-4 years	MOH/UWI	M: 15.7 F: 17.2	2004	Increase by 0.5	2009	Yes

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #1: PREVENTION										
OUTCOME										
	UNGASS, CIMT	UN-GE 12. Percentage of young women and men aged 15-24 who had sex with a non-marital, non-cohabiting sexual partner in the last 12 months	KABP	2004 and every 3-4 years	NAP M&E Unit	M:89% F: 78%	2004			Yes
	Global Fund	GF 7. Percentage of youth 15-19 years who reported no sexual activity in the last 12 months	Healthy Lifestyles Survey/KABP	every 3 - 4 years	MOH/ UWI	48% M:27.6% F:50.5%	2000 2004	M:> 30% F: > 50%	FY 08	Yes
	Global Fund,	GF 8. Percentage of 15-49 year olds who reported having sex with multiple partners in the last 12 months	KABP	2004 and every 3-4 years	NAP M&E Unit	M: 54% F: 15% M: 48% F: 11%	2000 2004	M: 47% F: 15%	FY 08	Yes
	CIMT	CIMT 3 % of people 15-49 years old who can access a condom almost immediately (less than 5 minutes)	KABP	2004 and every 3-4 years	NAP M&E Unit					Yes
OUTPUT & PROCESS										
Purpose	Global Fund, USAID	USJ 9. Number of individuals reached through TCI including vulnerable groups, (e.g. youth, MSM, CSW, prisoners, etc.)	Stakeholder & Regional Technical reports	Monthly	BCC & HIV Coordinators	200,000	2005	240,000 then increase by 100% annually	2012	Yes - being implemented
Purpose P7-P10, P12, P16		Number of persons trained to provide services by client and service area	Stakeholder & Regional Technical reports	Monthly	BCC & HIV Coordinators					

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #1: PREVENTION										
OUTPUT & PROCESS										
	World Bank	WB 6. Number of peer educators trained for each high risk group (CSW, MSM, prisoners, out-of-school youth)	Stakeholder & Regional Technical reports	Monthly	BCC /HIV Coordinators					Yes - being implemented
	Global Fund	GF 39. Number of commercial sex workers and MSM reached through prevention activities	Stakeholder & Regional Technical reports	Monthly	BCC & HIV Coordinators	300 CSW 300 MSM	2005	Cumulative 840 CSW 620 MSM 1320 CSW 980 MSM	FY 08 FY 09	
	Global Fund	GF 40. Number of service deliverers trained on HIV/AIDS prevention	Stakeholder & Regional Technical reports	Monthly	BCC /HIV Coordinators	125	2003	510	FY 08	
	PEPFAR	PEP 4.1. Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	Stakeholder PEPFAR Reports: MOH BCC	Annually	NAP M&E Unit	48	2006			
	PEPFAR	PEP 4.2. Number of individuals trained to promote HIV/AIDS prevention <i>beyond</i> abstinence and/or being faithful	Stakeholder PEPFAR Reports: MOH BCC	Annually	NAP M&E Unit	56	2006			
	PEPFAR	PEP 4.13. Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment	Stakeholder PEPFAR Reports: MOH BCC, IISPEC, SDC	Annually	NAP M&E Unit	542	2006			

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #1: PREVENTION										
OUTPUT & PROCESS										
	PEPFAR	PEP 5.1. Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful.	Stakeholder PEPFAR Reports: MOH BCC, SDC	Annually	BCC/ HIV Coordinators & M&E Unit	3,271	2006			Yes - being implemented
	PEPFAR	PEP 5.2. Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behaviour change <i>beyond</i> abstinence and/or being faithful	Stakeholder PEPFAR Reports: MOH BCC	Annually	BCC/ HIV Coordinators & M&E Unit	69,417	2006			Yes - being implemented.
PRIORITY AREA #2: TREATMENT, CARE & SUPPORT										
IMPACT										
GOAL	UNGASS, CARICOM	UN-GE 16. Percentage of adults & children with HIV still alive 12 months after initiation of ART	Treatment database from EMR	Monthly	Treatment coordinator	75%	2006	90%	2012	In development, 2004 estimate based on UNGASS calculations
T2	UNGASS, Global Fund, GoJ, USAID	UN-GE 17. Percentage of infants born to HIV-infected mothers [who are HIV-infected]	Regional HIV/AIDS Monthly Report (RHAMR)	Monthly	Regional Surveillance Officers & HIV Coordinators	25% 12% 10%	2000 2005 5006	< 10% < 5%	2007 2012	Regional Report; PMTCT database needs full implementation

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #2: TREATMENT, CARE & SUPPORT										
OUTCOME										
T5	UNGASS	UN-GE 14. Ratio of current school attendance among orphans to that among non-orphans, aged 10-14	MICS	every 5 yrs (Nov-Mar 2005-06)	UNICEF	0.99	2005	Maintain >0.9	2012	Yes
PURPOSE, T1	UNGASS	UN-C/LP 3. Percentage of most-at-risk populations (youth, MSM, CSW) who received HIV testing in the last 12 months and who know the results	Surveys (MSM, CSW, Healthy Lifestyles)	every 2 yr	NAP M&E Unit	CSW: 43%	2005	50%	2012	Yes
PURPOSE, T3	UNGASS, Global Fund,	GF 23. Percentage of men, women & children with advanced HIV receiving antiretroviral combination therapy according to national guidelines	Treatment site reports	Monthly	Regional Surveillance Officers/ Treatment coordinator	Adult: 50 Children:0 ?2745	2003 2006	Adult: 4,800 Children: 200, then 500/year	2009	Yes
T4	Jamaica National	Percentage of PLWHA on ARV reporting at least 90% adherence by pill count	National Health Fund Database Adherence counselor/ social worker reports	Monthly	Adherence counselors, social workers, HIV Coordinators	75%	2006	>80%	2012	Yes

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #2: TREATMENT, CARE & SUPPORT										
OUTCOME										
T9		Proportion of confirmed TB cases tested for HIV	Regional Surveillance Officer Reports NPHL Reports	Quarterly Quarterly	Regional Surveillance Officers NPHL	85%	2005	100%	2012	Yes Yes
T9		Percentage of HIV positive TB patients who began or continued ARV during TB treatment	Regional Surveillance Officer Reports	Quarterly	Regional Surveillance Officers	TBD				Yes
T10		Incidence of congenital syphilis	Case reporting	Annually	STI Officer	26.2 per 100,000 births	2004	15 per 100,000 births	2012	
	World Bank, GoJ	WB 9. Percentage of ANC clients that are counselled and tested for HIV	Regional HIV/AIDS Summary Report form	Monthly	Regional Surveillance Officer/ HIV coordinators					Yes
	World Bank	WB 10. Percentage of public sector clinicians of AIDS patients who manage OIs in adults according to national guidelines	Health Facility assessment	every 2-3 years	NAP M&E Unit					Not yet developed
	Global Fund, UNGASS, CIMT	UN-GE 6. Percentage of HIV positive pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT	Regional HIV/AIDS Summary Report form	Monthly	Regional Surveillance Officer/ HIV coordinators	< 10% 47% 74%	2002 2004 2005	80% 85%	FY 08 FY 09	Yes

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #2: TREATMENT, CARE & SUPPORT										
OUTCOME										
	UNGASS, CIMT	UN-GE 8. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child	MICS	every 5 yrs (Nov-Mar 2005-06)	UNICEF	TBD	2006			Yes. MICS will be completed in 2006
	Global Fund, CIMT	GF 19. Number of individuals tested for HIV according to guidelines	Regional HIV/AIDS Summary	Monthly	Regional HIV coordinator/ NPHL	25,000	?	280,000 480,000	FY 08 FY 09	Yes
	Global Fund	GF 21. Number of infants born to HIV+ mothers receiving PCR testing according to national standards	Regional HIV/AIDS Summary Report form	Monthly	Treatment coordinator	0	2003	Cumulative 650 850	FY 08 FY 09	Yes
	Global Fund	GF 24. Number of individuals (children & adults) receiving CD4 tests in the public sector according to national guidelines	Lab reports	Monthly	Treatment Coordinator	0	2003	Cumulative 2500 3000	FY 08 FY 09	Yes - needs refinement
	Global Fund, CIMT	GF 25. Number of individuals (children & adults) on ART receiving viral load testing in accordance with guidelines	Lab reports	Monthly	Treatment Coordinator					Yes - needs refinement

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #2: TREATMENT, CARE & SUPPORT										
OUTPUT & PROCESS										
T8, T12		<i>Number of persons trained to provide services by client and service area</i>	<i>Stakeholder & Regional Technical reports</i>	<i>Monthly</i>	<i>BCC & HIV Coordinators</i>					<i>*repeat</i>
	World Bank, CIMT	WB 7. Percentage of health districts with at least one trained counsellor providing VCT counselling	National VCT Coordinator records	Quarterly	VCT & Treatment Coordinator			100%	2006	Yes
	World Bank	WB 8. National Public Health Lab turn-around time for HIV testing	Public Health Lab records	Annually	National Public Health Lab			If negative <=7 working days; If positive in 14 days	Yes	
	Global Fund	GF 26. Number of public sector sites offering ARVs	Treatment Coordinator records	Annually	Treatment Coordinator					N/A
	Global Fund	GF 27. Number of PLWHA receiving adherence counselling	Treatment Site reports	Monthly	Treatment Coordinator	0	2003	3,800 adults 4,800 adults	FY 08 FY 09	N/A
	Global Fund	GF 32. Number of adherence support groups started by NGO/PAC partnerships using trained PLWHA	Stakeholder reports	Monthly	Global Fund Coordinator	0	2003	Cumulative 10 12	FY 08 FY 09	Yes

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #3: ENABLING ENVIRONMENT & HUMAN RIGHTS										
OUTCOME										
E4	UNGASS, CIMT	UN-GE 4. Percentage of large enterprises/ companies that have HIV/AIDS workplace policies and programs	Workplace Survey (25 private, 5 public)	Nov 2005 & every 2-3 years	Ministry of Labour/M&E Unit	10%	2005	30%	2012	Yes
GOAL	Global Fund, CIMT	GF 42. Percentage of people 15-49 yrs expressing accepting attitudes towards people with HIV/AIDS	KABP	2004 and every 3-4 years	NAP M&E Unit	M:8.7% F: 93%	2004	25%	2011	Yes
PURPOSE, E5		Number and percent of reported cases of HIV-related discrimination receiving redress by setting	MOE, Red Cross, Ministry of Labour, JAS	Quarterly	Stigma & discrimination working group	50%	2006	75%	2012	Needs to be refined
	Global Fund	GF 33. Number of large (>100 employees) private organizations not requiring pre-employment HIV tests	Workplace Survey	Nov 2005 & every 2-3 years	Ministry of Labour/M&E Unit	40	2003	70	FY 07	Yes
OUTPUT & PROCESS										
E2		<i>Number of persons trained to provide services by client and service area</i>	<i>Stakeholder & Regional Technical reports</i>	<i>Monthly</i>	<i>BCC & HIV Coordinators</i>					<i>*repeat</i>
E8		Number of policy makers attending sensitisation workshops on HIV/AIDS/STI						100% increase over baseline	2012	

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #3: ENABLING ENVIRONMENT & HUMAN RIGHTS										
OUTPUT & PROCESS										
	PEPFAR	PEP 3.1. Number of local organizations provided with technical assistance for HIV-related policy development	Stakeholder PEPFAR Reports: Constella Futures	Annually	NAP M&E Unit					
	PEPFAR	PEP 3.2. Number of local organizations provided with technical assistance for HIV-related institutional capacity building	Stakeholder PEPFAR Reports: MOH BCC, Deloitte & Touche, IISPEC, Constella Futures, UWI-HARP, MEASURE Evaluation	Annually	NAP M&E Unit	55	2006	110	2012	
	PEPFAR	PEP 4.10. Number individuals trained in HIV-related policy development	Stakeholder PEPFAR Reports: Deloitte & Touche, Constella Futures	Annually	NAP M&E Unit					
	PEPFAR	PEP 4.11. Number individuals trained in HIV-related institutional capacity building	Stakeholder PEPFAR Reports: Deloitte & Touche, IISPEC, SDC, Constella Futures, MEASURE Evaluation	Annually	NAP M&E Unit	48	2006			

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
EMPOWERMENT & GOVERNANCE										
OUTCOME										
GOAL, PURPOSE	UNGASS	UN-GE 2. National Composite Policy Index	Country assessment	Every 2 years	NAP M&E Unit					UNGASS tool adapted
	World Bank	WB 15. Percentage of project funding disbursed for HIV activities utilized by NGOs, CBOs, FBOs	Accounting/ Stakeholder Database	Quarterly	Finance Team					Yes
	World Bank	WB 16. Annual project funding disbursed by RHAs and parishes for HIV/AIDS activities	Accounting/ Stakeholder Database	monthly	Finance Team					Yes
	World Bank	WB 17. Recurrent second generation surveillance of: general population; vulnerable populations	Surveys (CSW, MSM, Healthy Lifestyles)	every 2-3 yr; quarterly	NAP M&E Unit & consultant					In development
	UNGASS, Global Fund, CIMT	UN-GE 1. Amount of national funds disbursed by government	UNFPA Survey of fin resource flow/ Financial database	Annually	Finance unit & NAP M&E Unit	2004/2005 HIV prevention STD/HIV/AIDS: Clinical care & treatment: HIV/AIDS Impact Mitigation Total	J\$12,602,125 J\$146,734,310 J\$283,327,380 J\$283,327,380 US\$4,722,123	Yes		

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
EMPOWERMENT & GOVERNANCE										
OUTPUT & PROCESS										
G1		<i>Number of persons trained to provide services by client and service area</i>	<i>Stakeholder & Regional Technical reports</i>	<i>Monthly</i>	<i>BCC & HIV Coordinators</i>					<i>*repeat</i>
G3	PEPFAR	PEP 4.9. Number of individuals trained in strategic information (M&E and/or surveillance and/or HMIS)	Stakeholder PEPFAR Reports: MOH M&E Unit, IISPEC, MEASURE	annually	NAP M&E Unit	80	2006	100 per year i.e. 500 by 2012	2012	Yes
G6	UNGASS	UN-GE 3. Percentage of schools with teachers who have been trained in the revised life-skills based HIV/AIDS education and who taught it during the last academic year	Educational program review	Every 2 years	Ministry of Education, focal point	5%	2006	80%	2012	Revised HFLE curriculum piloted in 24 schools in 2006. 2005 MOE programme estimate
G6		Number of NGOs providing HIV/AIDS prevention, treatment, care and support services according to national guidelines/standards	Stakeholder reports	Monthly	NAP M&E Unit/ Prevention Coordinator	?				Yes
G7		<i>Number of policy makers attending sensitisation workshops on HIV/AIDS/STI</i>	<i>Stakeholder reports</i>	<i>Monthly</i>	<i>Policy Coordinator</i>	<i>TBD</i>				Yes

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
EMPOWERMENT & GOVERNANCE										
OUTPUT & PROCESS										
	World Bank	WB 13. Management Information System developed for routine reporting (M&E Unit in MOH and Regional Authorities)	NAP progress reports	<i>as completed</i>	NAP M&E Unit					N/A
	World Bank, Jamaica National	WB 14. Completion of computerization for: National Public Health Lab; National Blood Transfusion Services; surveillance system; national and regional treatment centre drug inventory	NAP progress reports	<i>as completed</i>	NAP M&E Unit					N/A
	PEPFAR	PEP 2.1. Number of local organizations provided with technical assistance for strategic information activities (M&E and/or surveillance and/or HMIS)	Stakeholder PEPFAR Reports: IISPEC, MEASURE	Annually	NAP M&E Unit	1	2006			Yes
	CIMT	CIMT 5. Number of individuals trained in HIV-related community mobilization and for prevention, care and/or treatment (male & female)	Stakeholder & Regional Technical reports	monthly	Regional HIV & BCC Coordinators/F 135 NAP M&E Unit					Yes
	CIMT	CIMT 6. Number of indigenous organizations provided with technical assistance for HIV-related institutional capacity building	Stakeholder & Regional Technical reports	monthly	Regional HIV Coordinator/ NAP M&E Unit					Yes