

Jamaica UNGASS Report

January 2003 - December 2005



Declaration of commitment on HIV/AIDS

*Ministry of Health
Jamaica*

Jamaica UNGASS Report

Reporting period: January 2003 - December 2005

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral Therapy
CRIS	Country Response Information System
CSWs	Commercial Sex Worker
GAMET	Global HIV/AIDS Monitoring and Evaluation Team
HFLE	Health and Family Life Education
HIV	Human Immunodeficiency Virus
JN+	Jamaica Network of Seropositives
KABP	Knowledge, Attitude, Behaviour, and Practice
M&E	Monitoring & Evaluation
MEASURE	Monitoring and Evaluation to Assess and Use Result
MSMs	Men who have Sex with Men
NAP	National AIDS Programme
NGO	Non-Government Organisation
OVC	Orphans and Vulnerable Children
PLACE	Priority for Local AIDS Control Effort
PLWHA	Persons Living With HIV/AIDS
PMTCT	Prevention of Mother To Child Transmission
STDs	Sexually Transmitted Diseases
UNAIDS	United Nation programme and AIDS
UNGASS	United Nation’s General Assembly Special Session on HIV/AIDS
UNICEF	United Nation International Children’s Educational Fund
VCT	Voluntary Counselling and Testing

I. Status at a glance - Core Indicators, Jamaica
2006 reporting
(See Annex 1 for details of data source)

Indicators											
National Commitment & Action											
Expenditures											
1. Amount of national funds disbursed by governments (2004 – Program estimate & accounting database)	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #A9A9A9;">Program area</th> <th style="background-color: #A9A9A9;">J\$</th> </tr> </thead> <tbody> <tr> <td>HIV prevention</td> <td style="text-align: right;">12,602,125</td> </tr> <tr> <td>STD/HIV/AIDS Clinical care & treatment</td> <td style="text-align: right;">146,734,310</td> </tr> <tr> <td>HIV/AIDS impact mitigation**</td> <td style="text-align: right;">123,990,944.70</td> </tr> <tr> <td>TOTAL</td> <td style="text-align: right;">283,327,379.70 (US \$4,722,123.00)</td> </tr> </tbody> </table>	Program area	J\$	HIV prevention	12,602,125	STD/HIV/AIDS Clinical care & treatment	146,734,310	HIV/AIDS impact mitigation**	123,990,944.70	TOTAL	283,327,379.70 (US \$4,722,123.00)
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TOTAL	283,327,379.70 (US \$4,722,123.00)										
Policy Development and Implementation Status											
2. National Composite Policy Index Areas covered: prevention, care and support, human rights, civil society involvement, and monitoring and evaluation Target groups: people living with HIV/AIDS, women, youth, orphans, and most-at-risk populations	See Annex 2										
National Programmes: education, workplace policies, STI case management, blood safety, PMTCT coverage, ART coverage, and services for orphans and vulnerable children											
3. % of schools with teachers who have been trained in life-skills based HIV/AIDS education and who taught it during the last academic year	50%. Revised HFLE curriculum just being piloted in 24 schools (2005 Ministry of Education Program Estimate)										
4. % of large enterprises/companies which have HIV/AIDS workplace policies and programmes	10% (2005 – workplace survey)										
5. % of women and men with STIs at health care facilities who are appropriately diagnosed, treated and counselled	TBD										
6. % of HIV positive pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT	47% (2004 – PMTCT Program monitoring)										
7. % of women and men with advanced HIV infection receiving antiretroviral combination therapy	50% (2005 – ARV Program monitoring)										
8. % of orphans and vulnerable children whose households received free basic	Multiple indicator cluster survey is being conducted by UNICEF and will be completed in 2006.										

external support in caring for the child	
9. % of transfused blood units screened for HIV	100%
National Programmes: HIV testing and prevention programmes for most-at-risk populations	
10. % (most-at-risk populations) who received HIV testing in the last 12 months	43% (2005 second generation surveillance of 450 CSWs)
11. % (most-at-risk populations) reached by prevention programmes	60% (2005 second generation surveillance of 450 CSWs)
Knowledge and Behaviour	
12. ** % of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (Target: 90% by 2005; 95% by 2010)	38.1% of 15-24 y.o; 45.9% of 25-49 y.o (2004 National KABP) M 22.8% F 46.7%
13. % of (most-at-risk population(s)) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	26.1% (2005 second generation surveillance of CSWs)
14. Female and male median age at first sex	17.2 females ; 15.7 males (2004 National KABP)
15. % of young women and men aged 15-24 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months	77.7% females, 89% male (2004 National KABP)
16. ** % of young women and men aged 15-24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner	74% Males (2004 National KABP) 66% females
17. % of female and male sex workers reporting the use of a condom with their most recent client	84.3% (2005 second generation surveillance of CSWs)
18. % of men reporting the use of a condom the last time they had anal sex with a male partner	TBD (survey will begin in January 2006)
19. ** Ratio of current school attendance among orphans to that among non-orphans, aged 10-14	TBD from MICS (UNICEF survey to be completed by 2006)
20. ***% of young women and men aged 15-24 who are HIV infected (Target: 25% in most affected countries by 2005; 25% reduction globally by 2010)	
	1.1% (2004 sentinel surveillance of ANC clients) 1.5% (2005 sentinel surveillance of ANC clients)

21. % of (most-at-risk population(s)) who are HIV infected	9% (2005 second generation surveillance of CSWs)
22. % of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy	Not available
23. % of infants born to HIV infected mothers who are infected (Target: 20% reduction by 2005; 50% reduction by 2010)	6% (2004 Program monitoring and estimates UNGASS calculations)
** Millennium Development Goals	

TBD = To be determined

II. OVERVIEW OF THE HIV/AIDS EPIDEMIC IN JAMAICA

Jamaica is the third largest island in the Caribbean with a total area of 11,244 square kilometers. In 2004, the mean population of the island was 2.6 million and it is estimated that 1.5% of the adult population is living with HIV/AIDS (22,000 persons) and 4,000 persons have advanced HIV.

At the end of June 2005, the cumulative AIDS case rate was 372.4 cases per 100,000 population and a cumulative total of 9,682 cases of AIDS were reported. HIV/AIDS continues to claim over 600 lives annually (665 AIDS deaths reported in 2004). Although all parishes are affected by the epidemic, the two most urbanized parishes continue to have the highest number of cases (Kingston & St. Andrew: 595.5 cases per 100,000 population and ST. James: 830.0 cases per 100,000 population).

As in other Caribbean countries, women are increasingly affected by HIV/AIDS. The adult male: female ratio declined from 2.6:1 in 1988 to 1.3: 1 in 2000. However, the male: female ratio has remained stable between 1.2 to 1.3: 1 over the last 4 years. The majority of AIDS cases occur in the 20 to 39 year-old age group with 34% of cases occurring between 30 to 39 years old and 20% of cases between 20 to 29 year old .

TABLE 1: SUMMARY OF AIDS CASES IN JAMAICA

PERIOD	TOTAL	MALE (%)	FEMALE (%)
Cumulative 1982-2005	9682	5703 (58.9%)	3979 (41.1%)
Jan - Dec. 2000	903	515 (57.0)	388 (43.0)
Jan - Dec. 2001	939	511 (54.4)	428 (45.6)
Jan - Dec. 2002	989	580 (58.6)	409 (41.4)
Jan - Dec 2003	1070	611 (57.0)	459 (43.0)
Jan - Dec 2004	1112	603 (54.2)	509 (45.8)
Jan - June 2005	473	275 (58.1%)	198 (41.9%)

Among reported AIDS cases on whom risk data are available (72% of cases), the main risk factors are multiple sex partners, history of STDs, crack/cocaine use, and commercial sex (see Table 2). Among reported **male** AIDS cases on whom data about sexual practices are available (63% of cases), homosexual or bisexual activity is reported by 7.7% of men. As in previous years, intravenous drug use is reported by a minority of AIDS cases (1.1%)¹.

Table 2: AIDS cases in Jamaica by Risk Category ((1982 – June 2005 cumulative)

Total (6,956 reported)	
RISK	No. of Persons (%)
Commercial Sex	1781 (26)
Crack , Cocaine Use	623 (9)
STD History	3266 (47)
IV Drug Use	75 (1)
Multiple Sexual Partners/contacts	(>80%)

Despite a well established national surveillance system, collection of data in some high risk groups remains sparse. Men who have sex with men (MSMs) do not readily reveal sexual orientation due to stigma and discrimination. This leads to reduced access to prevention interventions and surveillance activities. Other populations such as CSWs are highly mobile and mapping procedures may not capture the highest risk persons in that population. For example, a 2005 second generation surveillance of CSWs in the most urbanized parishes in Jamaica showed an HIV prevalence of 9%. However, previous surveys have indicated an HIV prevalence as high as 20% in Montego Bay. ²

Sentinel surveillance indicates that there is no significant change in HIV prevalence among young people or among STI clinic attendees within the last year. Among ANC clinic attendees the HIV prevalence was 1.25% in 2004 and 1.51% in 2005. Among STI clinic attendees the HIV prevalence was 3.75% in 2004 and 4.64% in 2005³

Table 4: HIV Sero-prevalence in pregnant women, Jamaica, 2003 and 2004

PARISH	2003			2004			2005		
	Total tested	Total +ve	% +ve	Total tested	Total +ve	% +ve	Total tested	Total +ve	% +ve
Kingston & St. Andrew	1289	27	2.09	1214	21	1.73	1128	16	1.42
Manchester	325	4	1.23	349	3	0.86	322	6	1.86
St. Ann	472	6	1.27	313	1	0.32	290	5	1.72
St. Catherine	589	5	0.85	904	12	1.33	835	9	1.07
St. James	405	10	2.47	329	5	1.52	303	6	1.98
Westmoreland	283	4	1.41	261	0	0	240	5	2.08
Total	3363	56	1.67	3370	42	1.25	3118	47	1.51

Table 5: HIV Sero-prevalence in STI clinic attenders, Jamaica, 2003 and 2004

PARISH	2003			2004			2005		
	Total tested	Total +ve	% +ve	Total tested	Total +ve	% +ve	Total tested	Total +ve	% +ve
Kingston & St. Andrew	1742	98	5.63	1416	66	4.66	1361	74	5.44
Manchester	136	2	1.47	283	4	1.41	221	6	2.70
St. Ann	347	13	3.75	369	10	2.71	419	17	4.07
St. Catherine	624		1.44	630	19	3.02	600	22	3.66
St. James	536	46	8.58	356	15	4.21	520	30	5.77
Westmoreland	127	8	6.30	143	6	4.20	113	1	0.88
Total	3512	176	5.01	3197	120	3.75	3234	150	4.64

Jamaica established a public access to ARV treatment in September 2004 with the support of the UN Global Fund. Since its inception, 50% of persons with advanced HIV have been placed on ARV treatment. In 2004, widespread implementation of the pMTCT program resulted in testing of more than 90% of pregnant women attending public antenatal clinics and the most recent national survey confirmed that public knowledge of pMTCT is high among women (63%).⁴

At the end of December 2004, at least 47% of HIV-infected mothers received ARVs for pMTCT. This calculation probably under-estimates the impact of the pMTCT program since the number of mothers receiving ARVs for PMTCT do not include HIV-infected mothers seen in the private sector as this data is not captured by the current surveillance system.

III. National response to the HIV/AIDS epidemic

National Commitment

The commitment of the Government of Jamaica and the Ministry of Health in the fight against HIV/IDS is evidenced by the drafting of a National HIV/AIDS Policy in 2005. Several ministries of government and private organizations have adopted sector HIV/AIDS policies and are active stakeholders in the national response to HIV/AIDS. In addition, the Epidemiology Research and Training Unit of the Ministry of Health of Jamaica is a HIV Vaccine Trial Unit and will be recruiting persons for phase 11 and phase 11b HIV vaccine clinical trials in February 2006. Annually, over 4 million dollars of national funds have been spent directly on HIV/AIDS (Table 6).

Table 6: Expenditure of national funds on HIV/AIDS by program area

Program area	2004 (J\$)
HIV prevention	12,602,125
STD/HIV/AIDS Clinical care & treatment	146,734,310
HIV/AIDS impact mitigation**	123,990,944.70
TOTAL	283,327,379.70* (US \$4,722,123.00)

*Does not include some indirect costs such as professional costs at primary and secondary health care levels, laboratory costs, and costs of other support services

The national policy recognizes that an effective response to the HIV/AIDS epidemic requires respect for and protection of all rights - human, civil, political, economic, social and cultural. The principal focus of the national response is the prevention of new HIV infections; the treatment, care, and support of those infected or affected by HIV/AIDS; mitigation of the impact of the epidemic; strengthening of the enabling environment including legislative changes and the reduction of HIV/AIDS related stigma and discrimination.⁵

The 2002-2006 National HIV/AIDS Strategic Plan identified programming priorities, and areas in which to focus future actions for all sectors, based on principles in keeping with regional and international commitments.⁶

The five priority areas that were identified are:

1. Policy, advocacy, legal and human rights:

Legal and Policy Framework for the Protection of Human Rights of PLWHA and Those Affected by HIV/AIDS

2. Integrated and multi-sectoral response:

Development and dissemination of sectoral HIV/AIDS policy and sectoral plans to reduce stigma and discrimination.

3. Prevention:

Effective Behaviour Change Intervention and Communication (BCIC)

Affordable condoms accessible to sexually active men, women and young persons.

Prevention of MTCT

Increased HIV testing

Improved STI Prevention and Control

Safe blood transfusion service

Post-exposure prophylaxis for health care workers

4. Care treatment and support:

Improved access to and quality of care and support for persons infected with or affected by HIV.

5. Monitoring, surveillance and evaluation:

Develop an accurate, efficient, unified and standardized reporting and surveillance system

Prevention, Knowledge and Behaviour Change

Despite several educational campaigns, school and community interventions, the National Knowledge, Attitudes, Behaviour and Practices (KABP) survey, which has been conducted since 1988, suggests that there has been no significant change in high risk behaviours or condom use among persons 15-49 years old over the last decade.

The KABP survey is a national survey that is conducted every 2-3 years. The survey aims to measure the effect of prevention activities on knowledge and attitudes that determine appropriate safe sex practices, as well as actual behaviour. The 2004 survey was a cross-sectional survey of a randomly selected sample of 1800 persons nation-wide.

Respondents represented persons aged 15-49 years with the younger group of 15-24 year old persons over sampled (for analysis purposes). Face-to-face interviews were conducted. The data collection instrument utilized indicator measures and definitions consistent with the UNAIDS and the USAID Priority Prevention Indicator (PPI).

In summary, general knowledge about HIV and how to prevent it is high but inaccurate perceptions about HIV/AIDS transmission (such as mosquito bites) persist. This is evidenced by the fact that only 36% of young men and 40% of young women were able to correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about AIDS. In addition, high risk behaviours such as having unprotected sex, multiple sex partners and sex with commercial sex workers were reported by a significant portion of the general population (table 7).⁴

Table 7: Behavioural indicators from 2004 National KABP, Jamaica

INDICATOR	2000	2004
% of young people 15-24 who both correctly identify ways of preventing the sexual transmission of HIV & who reject major misconceptions about HIV transmission	M -29.6% F – 33.4%;	M -36.2% F - 40.0%; 15-24 years: 38.1 25-49 years: 45.9%
Proportion endorsing correct preventive practices <i>15-24 year olds must endorse 3 preventive practices: condom use always, one faithful partner, abstinence</i> <i>25-49 year olds must endorse 2 preventive practices: condom use always, one faithful partner</i>	Not available	<u>Males:</u> 15-24 years: 75.2% 25-49 years: 78.6% <u>Female:</u> 15-24 years: 74.3% 25-49 years: 78.3%
Proportion of respondents having misconceptions about HIV/AIDS: <i>1. Avoid being bit by mosquito</i> <i>2. Avoid sharing food with PLWHA</i> <i>3. Avoid touching person with AIDS</i>	Male Female 36.7% 25.7% 22.0% 14.2% 14.7% 8.1%	Male Female 20.4% 14.3% 21.2% 17% 10% 7.6%
% of young women and men aged 15-24 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months	N/A	77.7% females 89% male
% of young women and men aged 15-24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner	77.3% males 71.7% females	74.0% males 65.9% females
Percent of Persons 15-49 having Multiple Partners in the last 12 mths	52.9% males 18.9% females	48.7% males 10.8% females

Behavioural surveillance of high risk groups such as commercial sex workers (CSWs) and men who have sex with men (MSMs) have been challenging, partly due to stigma and discrimination, which makes accessing these populations difficult. Consequently, sampling methodologies employed have traditionally involved convenience sampling and snowballing, which may not necessarily provide a true representation of these high risk groups.

A 2005 survey of CSWs was conducted in the parishes with the highest HIV/AIDS prevalence. This revealed that knowledge about ways to prevent HIV/AIDS transmission was high but rejection of myths was low, as in the general population. Ninety-seven percent of CSWs reported having easy access to condoms (accessible within 5 minutes) and condom use with clients ($\geq 90\%$) was significantly higher than condom use with non-paying partners (52%). HIV prevalence was found to be 9% in this population, no significant change over the last decade.²

In response to these findings, the national program reviewed the strategies to combat HIV/AIDS and new priorities emerged through consultation with stakeholders. These emphasized HIV counselling and testing, greater involvement of the education sector, and reduction of stigma and discrimination. The education sector has embraced its critical role in the national response by spearheading the revision of the Health and Family Life Education (HFLE) curriculum to incorporate HIV/AIDS issues. The revised curriculum is currently being pilot tested in 24 schools and wider implementation will occur in 2006.

Some new priorities that emerged in 2005 are outlined below:

Prevention

- HIV rapid testing, counseling, and referral
- Mapping of target populations
- Assess and improve prevention services for targeted populations
- Wider implementation of PLACE methodology
- Training of coordinators, peers, etc.
- Media campaign
- Data capture and monitoring

Policy, Human rights, & Stigma Reduction

- Reducing stigma
- Strengthening JN+ and role of PLWHA
- Increase programs by PLWHA
- Monitor stigma and discrimination
- Advocacy for legislation and justice
- Media Campaign

Expand sectorial response

- Tertiary institutions
- Life skills, health, and family life, sex education
- Other educational approaches

Treatment, Care and Support

Public access to antiretroviral medication began in September 2004 in Jamaica and there are 18 sites offering multidisciplinary care for persons living with HIV/AIDS. In addition, all major hospitals have adopted the prevention of mother-to-child transmission (pMTCT) program.

It is estimated that of the 22,000 PLWHA, two-thirds of infected persons are unaware of their status, and 4000 persons have advanced HIV and are in need of treatment. Based on programme monitoring, 1997 persons with HIV/AIDS (50% of persons with advanced HIV) were on treatment, one year after the start of the treatment program. However, data on survival after initiation of treatment is lacking and data collection tools are being developed and refined to capture this data.

In order to get more PLWHA on treatment, the following priority areas emerged from 2006 stakeholder consultations:

Expand HIV Testing

- Media campaign to increase awareness
- Logistical and Operational support
- Quality Assurance
- Counseling and Referral
- Data capturing and monitoring

Expand HIV/AIDS Treatment with ARV

- CD4 testing
- National Health Fund Tracking of ARV
- Adherence and Social Support
- Training of clinicians and providers
- Data capture and monitoring

Programmatic priorities that will strengthen care and support for PLWHA have also evolved. This includes implementation of home based care programs, strengthening adherence, increased advocacy for PLWHAs and services for children orphaned by HIV/AIDS.

The pMTCT program has also been a priority for the NAP. This has employed several strategies including offering counselling and testing for all mothers during antenatal care, CD4 tests for all HIV-infected mothers and provision of ARVs for HIV –infected mothers and infants. Presently, over 90% of pregnant women attending public antenatal clinics are tested for HIV and public knowledge of PMTCT is high among women (63%).⁴ In 2004, 28,750 women were seen at public antenatal clinics and it is estimated that 638 HIV-infected women delivered island-wide (public and private). Based on UNGASS calculation, at least 47% of HIV-infected mothers received ARVs for pMTCT and 6% of HIV-infected mothers delivered HIV-infected infants (>25% reduction). These calculations probably under-estimate the impact of the pMTCT program since the number of mothers receiving ARVs for PMTCT do not include HIV-infected mothers seen in the private sector as this data is not captured by the current surveillance system.

Impact Alleviation

Despite several initiatives, HIV/AIDS has remained the second most common cause of death for persons in the reproductive age group in Jamaica and various estimates of the number of children orphaned by HIV/AIDS have ranged from 5000 to 8000*.

Currently, data on support services for orphans is sparse. The most current data come from a pilot test of a survey designed to measure the situation of children orphaned and made vulnerable by HIV/AIDS. This was a project undertaken by UNICEF and other stakeholders in 2004. The purpose of the field test was to test a sampling methodology, to test new indicators developed for the *Guide to Monitoring and Evaluation of the National Response for Children Orphaned and Made Vulnerable by HIV/AIDS*. Kingston and

Blantyre (Malawi) were the two pilot sites for this survey. Children from 3 locations were surveyed: in households, in institutions (jails, orphanages, care facilities), or on the street.

Data regarding school attendance is summarized below. Note that the ratio of school attendance among orphans to that among non-orphans aged 10-14 was not reported because the sample was too small to accurately measure the indicator.⁷

	% of children surveyed who attend school
Setting	
Household	94.5
Institution	80.1
Street	17.6
OVC group	
Orphan ¹	82.1
Vulnerable ²	95.7
OVC³	89.5
Non OVC	95.4
Total	94.4

¹ Orphans were defined as all children who had lost one or both parents

² Children who were vulnerable due to HIV/AIDS were defined as those children whose parents had died or were chronically ill

³ Orphans and vulnerable children (OVCs) were defined as all children who had lost one or both parents, children whose parents were chronically ill, and children who lived in institutions, or who sleep on the street.

The Multiple Indicator Cluster survey (MICS) is an international survey and will be conducted in Jamaica in early 2006. This will provide current national data on care for orphans and vulnerable children.

IV. Major challenges faced and actions needed to achieve the goals/targets

Some of the challenges faced by the National HIV/AIDS program in achieving the goals and targets are highlighted below.

A. Data capturing: Despite the formation of the Monitoring and Evaluation (M&E) Unit in September 2004, the implementation of data collection tools continues to lag behind programme implementation. Many activities have been rolled out without adequate M&E systems in place and the true impact of programs are often underestimated due to incomplete data collection. This inadequacy is evident in both public and private sectors where the capacity of implementing stakeholders to conduct accurate surveillance is limited. Consequently, program monitoring and impact assessment is lacking in areas such as VCT, treatment, prevention, and pMTCT.

Additionally, the UNGASS report requires special surveys such as workplace and school surveys, which have not been part of routine data collection. The numerous conflicting, and sometimes duplicative, reports and surveys required by international and regional organizations impose a strain on human as well as financial resources.

Actions:

Several steps have been taken to bridge gaps in data capturing. These include:

- The expansion of the M&E Unit's team to include a database officer, M&E specialist, and a biostatistician.
- The development of new data collection tools which are currently being piloted. These include ART manual and electronic registers, data collection forms for VCT and stakeholder program monitoring.
- Design of M&E information systems to allow better tracking of data.
- The development of an M&E framework to facilitate streamlining of indicators from multiple organizations and donors.
- Conducting additional surveys to gather data on high risk groups (e.g. second generation surveillance of MSMs and survey of employers).
- Garnering technical support, which have been received from several international organizations including GAMET and MEASURE.
- Training of stakeholders on M&E.

B. Access to High Risk populations. Despite the widespread implementation of policies related to HIV/AIDS issues, stigma and discrimination continue to hamper the implementation of services for populations such as CSWs, PLWHAs and MSMs. Fear of being labelled and subsequently discriminated against has resulted in decrease access to BCC activities, decrease access to VCT services and hence testing for HIV, decreased early access to treatment when diagnosed with HIV and decreased access to pMTCT programs as HIV-infected mothers sometimes choose not to disclose their status at delivery.

Actions:

The following steps have been taken to increase access to services by high risk populations:

- Increased advocacy to revise legislations that criminalize homosexuality and prostitution.
- Increased advocacy for adoption of policies around HIV/AIDS issues in private sector.
- Strengthening of NGOs such as Jamaica Network of seropositives.
- Increase role of PLWHAs in the national response to HIV/AIDS.
- Media campaigns to increase awareness of availability of treatment, VCT services and to reduce stigmatisation.
- Mobilization of civil societies.
- Enhanced workplace programs.
- Monitoring of stigma and discrimination.

C. Need to Expand Prevention Programs. The NAP recognizes that rapid scaling up of prevention programs must be a priority for 2006. It is estimated that spending on prevention activities must be increased by ten-fold in order to have any impact on the epidemic in Jamaica. This must be approached in the context of limited human and financial resources as well as with the view of sustainability.

Actions:

Prevention activities will be scaled up by:

- Increased HIV rapid testing, counseling, and referral
- Mapping of high risk populations with increased outreach programs and targeted community interventions
- Increased human capacity to conduct prevention activities including training of coordinators, peers, etc

V. Support required from country's development partners

The developmental partners must support the activities of the NAP and thereby facilitate the emergence of the “Three Ones”. Consequently, the agendas of all stakeholders must be consistent with the national program's strategic plan and priorities and should contribute to the development and execution of one national program and M&E system.

This may be achieved by:

- Streamlining indicators and reporting requirements, which sometimes detract from other fundamental activities such as developing data collection tools and strengthening M&E systems.
- Strengthening relationships with key stakeholders.
- Establishing self as ambassadors and facilitators of the national response rather than obstacles.
- Facilitating financial and technical assistance when needed.

VI. Monitoring and evaluation environment

The National Composite Policy Index (NCPI) was developed to assess the country's commitment to programme efforts in response to HIV/AIDS. It is divided into two parts:

- a) **Part A**, administered to government officials
- b) **Part B**, administered to representatives from the governments' primary partners in the NGO sector and from international agencies.

Part A covers five broad areas:

1. Strategic plan
2. Political support
3. Prevention
4. Care and support
5. Monitoring and Evaluation (M&E)

Part B of the questionnaire was directed to representatives from the governments' primary partners including non-governmental organizations and international agencies. This section of the questionnaire had four components:

1. Human rights
2. Civil society involvement
3. Prevention
4. Care and support

Nineteen persons completed questionnaires and the data was captured in the Country response information System (CRIS).

In summary, the NCPI revealed that Jamaica has made good progress in the areas of strategic planning, and in attracting high level political support. The NAP has successfully implemented programmes such as public access to ARV treatment and has made a

significant difference in the impact of HIV/AIDS in the lives of individuals and communities.

However, areas such as behaviour change, legislative change and enforcement, care and support, and policy development must continue to be addressed.

A summary of the findings of the NCPI is found in Annex 2.

References

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ANNEX 1
UNGASS Report 2003-2005, Jamaica

UNGASS Indicator	Data Source	Values/ Date/s collected	Status of data collection systems, description of current methods, caveats etc.
1. Amount of national funds spent by governments on HIV/AIDS.	NHAP Finance team Program monitoring 2004 & 2005	HIV prevention J\$ 12,602,125* STD/HIV/AIDS Clinical care & treatment J\$146,734,310* HIV/AIDS impact mitigation J\$123,990,944.70* TOTAL J\$283, 327, 379.70* (US \$4,722,123.00)	Accounting database These figures exclude costs such as professional costs at primary and secondary care level, laboratory costs, and costs of other support services.
2. National Composite Policy Index (NCPI)	NCPI Survey	See Annex 2	
National Programmes: education, workplace policies, STI case management, blood safety, PMTCT coverage, ART coverage, and services for orphans and vulnerable children			
3. % of schools with teachers who have been trained in life-skills based HIV/AIDS education and who taught it during the last academic year	Program estimate – Ministry of Education	50% (2005)	A more structured life-skills based HIV/AIDS education program was developed by the Ministry of Education in 2004. This is being piloted in 24 schools. A special survey of schools will have to be undertaken to determine the numbers who have taught HFLE during the last year.
UNGASS Indicator	Data Source	Values/ Dates collected	Status of data collection systems, description of current methods, caveats etc.

<p>4. % of large enterprises/companies which have HIV/AIDS workplace policies and programmes</p>	<p>Survey of Workplaces and desk review</p>	<p>10% (2005)</p>	<p>A survey of 30 of the largest employers in Jamaica (public and private) was conducted in December 2005. Twenty-five employers from the private sector and 5 from the public sector were surveyed to assess the status of HIV and AIDS workplace policies and programmes. Employers were asked to state whether they are currently implementing personnel policies and programmes that cover, as a minimum, <i>all</i> of the following aspects: (a) the basic facts on HIV/AIDS; (b) specific work-related HIV transmission hazards and safeguards; (c) condom promotion; (d) VCT; (e) STI diagnosis and treatment and; (f) provisions for HIV/AIDS related drugs (d) prevention of stigma and discrimination in staff recruitment, promotion, termination, and sickness.</p>
<p>5. % of women and men with STIs at health care facilities who are appropriately diagnosed, treated and counselled</p>	<p>Survey of Health facilities</p>	<p>To be determined</p>	
<p>6. % of HIV positive pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT</p>	<p>Program monitoring</p>	<p>47% (2004)</p>	<p>No data on HIV-infected mothers treated in the private sector is available but the denominator is the estimate of the number of deliveries in both private and public sectors. Therefore, this is an underestimation of the outcome of the pMTCT program.</p>
<p>7. % of women and men with advanced HIV infection receiving antiretroviral combination therapy</p>	<p>Program monitoring</p>	<p>50% (September 2004 to October 2005)</p>	<p>Based on program monitoring: No. receiving ART at the end of September 2005: 1997 No. of people with HIV infection, government estimate: 22,000. No. of people with advanced HIV infection: 4,000 Percent of people with advanced HIV infection receiving antiretroviral combination therapy = $1949/4000 \times 100 = 50\%$</p>
<p>8. % of orphans and vulnerable children</p>	<p>MICS</p>	<p>To be determined</p>	<p>MICS will be completed in 2006</p>

whose households received free basic external support in caring for the child			
9. % of transfused blood units screened for HIV	National Blood bank Program monitoring	100% (2004 & 2005)	
Knowledge and Behaviour			
10. % 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	38.1% of 15-24 year old (2004) 45.9% of 25-49 year old (2004)	National survey, stratified multi-staged sample with quota controls. (Enumeration districts are selected with probability proportionate to size). Data was collected in confidential face-to-face interview. The questionnaire is a modification of global methods.
11. Female and male median age at first sex	KABP	17.2 females (2004) 15.7 males	As above
12. % of young women and men aged 15-24 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months	KABP	77.7% females (2004) 89% males (2004)	As above
13. % of young women and men aged 15-24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner	KABP	74.0% males (2004) 65.9% females (2004)	As above
UNGASS Indicator	Data Source	Values/ Dates collected	Status of data collection systems, description of current methods, caveats etc.
14. Ratio of current school attendance among orphans	MICS	TBD	MICS is scheduled to be completed in 2006.

to that among non-orphans, aged 10-14			
Impact			
15. % of young women and men aged 15-24 who are HIV infected	Sentinel Surveillance of ANC clinic attendees	1.1% (2004) 1.5% (2005)	
16. % of adults and children with HIV still alive 12 months after initiation of antiretroviral- therapy	Program monitoring	Not available	ARV registers are being pilot tested. Data will be available for 2006 report.
17. % of infants born to HIV infected mothers who are infected	Program monitoring	6% (2004)	
Concentrated Epidemics			
1. % (most-at-risk populations) who received HIV testing in the last 12 months	Second generation surveillance of CSWs	43% of CSWs (2005)	Cross sectional survey of 450 CSWs in Kingston & St. Andrew, St. Catherine, St. James, Westmoreland, nad St. Ann. A sampling frame was constructed by social mapping of sites based on information from key informants. Sites were randomly selected from each area. Convenience and snowball sampling were used to identify participants.
2. % (most-at-risk populations) reached by prevention programmes	Second generation surveillance of CSWs	60% of CSWs (2005)	As above
Knowledge and Behaviour			
3. % of (most-at-risk population(s)) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Second generation surveillance of CSWs	26.1% of CSWs	As above
4. % of female and male sex workers reporting the use of a condom with their most recent	Second generation surveillance of CSWs	84.3%	As above

client			
5. % of men reporting the use of a condom the last time they had anal sex with a male partner	Not available		Second generation surveillance of MSMs will begin in January 2006
Impact			
9.% of (most-at-risk population(s)) who are HIV infected	Second generation surveillance of CSWs	9% (2005)	As above

**ANNEX 2 –
National Composite Policy Index Summary, Jamaica**

Indicator	Data Origin	Period	Value
NCPI-A-I-1 : Country has developed a national multi-sectoral strategy/action framework to combat HIV/AIDS	Jamaica	2005	Yes
NCPI-A-I-2 : Country has integrated HIV/AIDS into its general development plans		2005	Yes
NCPI-A-I-3 : Country has evaluated the impact of HIV and AIDS on its economic development for planning purposes		2005	Yes
NCPI-A-I-4 : Country has a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services, military, peacekeepers and police		2005	Yes
NCPI-A-I-R : Strategy planning efforts in the HIV and AIDS programmes overall Rating		2003	7
		2005	8
NCPI-A-II-1 : The head of the government and/or other high officials speak publicly and favourably about AIDS efforts at least twice a year		2005	Yes

NCPI-A-II-2 : Country has a national multisectoral HIV and AIDS management/coordination body recognized in law? (National AIDS Council or Commission)		2005	Yes
NCPI-A-II-3 : Country has a national HIV and AIDS body that promotes interaction between government, people living with HIV, the private sector and civil society for implementing HIV and AIDS strategies/programmes		2005	Yes
NCPI-A-II-4 : Country has a national HIV and AIDS body that is supporting coordination of HIV-related service delivery by civil-society organizations		2005	Yes
NCPI-A-II-R : Political support for the HIV/AIDS programme overall rating		2005	7
NCPI-A-III-1 : Country has a policy or strategy that promotes information, education and communication (IEC) on HIV and AIDS to the general population		2005	Yes
NCPI-A-III-2 : Country has a policy or strategy promoting HIV and AIDS related reproductive and sexual health education for young people		2005	Yes
NCPI-A-III-3 : Country has a policy or strategy to promote information, education and communication and other preventive health interventions for most-at-risk populations		2005	Yes

NCPI-A-III-4 : Country has a policy or strategy to expand access, including among most-at-risk populations, to essential preventative commodities. (These commodities include, but are not limited to, access to confidential voluntary counselling and testing, condoms, sterile needles and drugs to treat sexually transmitted infections.)		2005	Yes
NCPI-A-III-R : Policy efforts in support of prevention overall rating		2003	4
		2005	6
NCPI-A-III-5 : Prevention activities have been implemented in 2003 and 2005 in support of the HIV-prevention policy/strategy		2003	Yes
		2005	Yes
NCPI-A-III-R2 : Efforts in the implementation of HIV prevention programmes overall rating		2003	6
		2005	7
NCPI-A-IV-1 : Country has a policy or strategy that promotes information, education and communication (IEC) on HIV and AIDS to the general population		2005	Yes
NCPI-A-IV-2 : Activities have been implemented under the care and treatment of HIV and AIDS programmes		2003	Yes
		2005	Yes

NCPI-A-IV-R : Efforts in care and treatment of the HIV/AIDS programme overall rating		2003	6
		2005	8
NCPI-A-IV-3 : Country has a policy or strategy to address the additional HIV and AIDS-related needs of orphans and other vulnerable children (OVC)		2005	Yes
NCPI-A-IV-R2 : Efforts to meet the needs of orphans and other vulnerable children overall rating		2003	6
		2005	7
NCPI-A-V-1 : Country has one national Monitoring and Evaluation (M&E) plan		2005	In Progress
NCPI-A-V-3 : There is a budget for the Monitoring and Evaluation plan		2005	Yes
NCPI-A-V-4 : There is a Monitoring and Evaluation functional Unit or Department		2005	Yes
NCPI-A-V-5 : There is a committee or working group that meets regularly coordinating Monitoring and Evaluation activities		2005	In Progress
NCPI-A-V-6 : Individual agency programmes have been reviewed to harmonize Monitoring and Evaluation indicators with those of your country		2005	Yes
NCPI-A-V-7 : Degree (Low to High) to which UN, bi-laterals, other institutions are sharing Monitoring and Evaluation results?		2005	6

NCPI-A-V-8 : The Monitoring and Evaluation Unit manages a central national database		2005	Yes
NCPI-A-V-9 : There is a functional Health Information System		2005	Yes
NCPI-A-V-10 : There is a functional Education Information System		2005	Yes
NCPI-A-V-11 : Country publishes at least once a year an evaluation report on HIV and AIDS, including HIV surveillance reports		2005	Yes
NCPI-A-V-12 : Extent to which strategic information is used in planning and implementation?		2005	8
NCPI-A-V-13 : In the last year, training in Monitoring and Evaluation was conducted		2005	Yes
NCPI-A-V-R : Monitoring and evaluation efforts of the HIV and AIDS programme overall rating		2003	6
		2005	7
NCPI-B-I-1 : Country has laws and regulations that protect people living with HIV and AIDS against discrimination		2005	Yes
NCPI-B-I-2 : Country has non-discrimination laws or regulations which specify protections for certain groups of people identified as being especially vulnerable to HIV and AIDS discrimination		2005	No

NCPI-B-I-3 : Country has laws and regulations that present obstacles to effective HIV prevention and care for most-at-risk populations		2005	No
NCPI-B-I-4 : The promotion and protection of human rights is explicitly mentioned in an HIV and AIDS policy/strategy		2005	Yes
NCPI-B-I-5 : The Government has, through political and financial support, involved vulnerable populations in governmental HIV-policy design and programme implementation		2005	Yes
NCPI-B-I-6 : Country has a policy to ensure equal access, between men and women, to prevention and care		2005	Yes
NCPI-B-I-7 : Country has a policy to ensure equal access to prevention and care for most-at-risk populations		2005	Yes
NCPI-B-I-8 : Country has a policy prohibiting HIV screening for general employment purposes (appointment, promotion, training, benefits)		2005	Yes
NCPI-B-I-9 : Country has a policy to ensure that HIV and AIDS research protocols involving human subjects are reviewed and approved by a national/local ethical review committee		2005	Yes
NCPI-B-I-10 : Country has monitoring and enforcement mechanisms		2005	Yes

NCPI-B-I-11 : Members of the judiciary have been trained/sensitized to HIV and AIDS and human rights issues that may come up in the context of their work		2005	No
NCPI-B-I-12 : Legal support services are available in the country		2005	Yes
NCPI-B-I-13 : There are programmes designed to change societal attitudes of discrimination and stigmatization associated with HIV and AIDS to understanding and acceptance		2005	Yes
NCPI-B-I-R : Policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS overall rating		2005	5
NCPI-B-I-R2 : Effort to enforce the existing policies, laws and regulations overall rating		2005	3
NCPI-B-II-1 : Extent to which civil society has made a significant contribution to strengthening the political commitment of top leaders and national policy formulation		2005	8
NCPI-B-II-2 : Extent to which civil society representatives have been involved in the planning and budgeting process for the National Strategic Plan on HIV and AIDS or for the current activity plan (attending planning meetings and reviewing drafts)		2005	7

NCPI-B-II-3 : Extent to which the complimentary services provided by civil society to areas of prevention and care are included in both the National Strategic plans and reports		2005	7
NCPI-B-II-4 : Country has conducted a National Periodic review of the Strategic Plan with the participation of civil society		2005	Yes
NCPI-B-II-5 : Extent to which country has a policy to ensure that HIV and AIDS research protocols involving human subjects are reviewed and approved by an independent national/local ethical review committee in which people living with HIV and caregivers participate		2005	9
NCPI-B-II-R : Efforts to increase civil-society participation overall rating		2003	5
		2005	8
NCPI-B-III-1 : Prevention activities have been implemented in 2003 and 2005 in support of the HIV-prevention policy/strategy		2003	Yes
		2005	Yes
NCPI-B-III-R : Efforts in the implementation of HIV prevention programmes overall rating		2003	6
		2005	7
NCPI-B-IV-1 : Activities have been implemented under the care and treatment of HIV and AIDS programmes		2003	Yes
		2005	Yes

NCPI-B-IV-R : Efforts in care and treatment of the HIV/AIDS programme overall rating		2003	6
		2005	9
NCPI-B-IV-2 : Country has a policy or strategy to address the additional HIV and AIDS-related needs of orphans and other vulnerable children (OVC)		2005	Yes
NCPI-B-IV-R2 : Efforts to meet the needs of orphans and other vulnerable children overall rating		2003	5
		2005	8

