
**Monitoring the Implementation of the UNGASS
Declaration of Commitment
Country Report
Jamaica**

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SECTION 1 EXECUTIVE SUMMARY
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This report provides an overview of the progress made by the Government of Jamaica in implementing the components of the Declaration of Commitment (DoC) signed in 2001 at the United Nations General Assembly Special Session on HIV/AIDS (UNGASS). It also examines the participation of civil society agents (CSAs), including the private sector, international entities and persons living with HIV/AIDS (PLWHAs), in this implementation process. Although not always within the timeframes identified by the DoC, the Government of Jamaica has made very good progress in implementing its commitments. Building on earlier control efforts dating back to the early 1990s, the Ministry of Health created the National HIV/STI Control Programme (also known as the National AIDS Programme or NAP), which subsequently drafted the Jamaica HIV/AIDS/STI National Strategic Plan 2002-2006. This comprehensive and multi-sectorial response to the epidemic lists five “Priority Areas” - Policy, Advocacy, Legal and Human Rights; Multi-sectorial Response (including workplans for 13 key sectors); Prevention; Care, Treatment and Support; and Surveillance, Monitoring and Evaluation. An outcome of this strategy was the recently released National HIV/AIDS Policy. This policy, based on a variety of international commitments (including the DoC) and standards including respect for human rights, identifies four main objectives dealing with prevention, treatment, socio-economic impact and policy/legislative environment. In implementing these objectives, the Policy calls for “zero-tolerance” for discrimination against PLWHAs.

The main co-ordinating mechanism for the implementation of this policy is the National AIDS Committee (NAC). This CSA, created in 1988, has received considerable assistance from the MOH to the extent that many considered it a unit within the ministry. Today, with its autonomy strengthened and its role expanded, it acts as a critical clearinghouse for information and monitor of implementation efforts in all sectors. Implementation efforts are undertaken by the NAP, the NAC, CSAs, the public sector and international partners. While the MOH undertakes much of the policy and treatment components, it also engages in prevention activities, especially behaviour change communication and national advertising campaigns. CSAs contribute in all areas but may have the strongest impact in the areas of prevention education and care and support. International entities including UNAIDS, UNDP, UNFPA, UNICEF, UNESCO, CIDA, USAID, ILO, IDB, the Global Fund and others have supported all phases of implementation especially prevention and treatment efforts.

The principal constraints to the implementation of the National Policy are social and cultural including a strong and intractable degree of stigma and discrimination, and widespread poverty. A lack of funding for hospitals, testing labs, and medical staff complicates the situation, as does a lack of capacity in both the public and private sectors, especially in the areas of financial management, and project monitoring and evaluation.

Civil society actors, PLWHAs, international partners and Government officials have suggested a variety of recommendations for improving the national response. Greatest among these is the continued effort to address stigma and discrimination. Also stressed were: 1) more effective coordination of efforts among all actors, 2) better monitoring and evaluation of projects to determine effectiveness, and 3) easier access to funds coupled with greater accountability and transparency.

SECTION 2 BASELINE STATISTICS
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Jamaica, an independent country within the British Commonwealth, lies approximately one hundred miles west of Haiti and ninety miles south of Cuba within the Caribbean Sea. Tourism generates the largest portion of the national economy with bauxite, agriculture and light manufacturing also contributing smaller yet still significant amounts. Although inflation dropped into the single digits in recent years since its 1992 high of 77%, the 2004 rate was estimated at 12.4% and double-digit inflation is predicted for the foreseeable future. Unemployment also remains high at an estimated 15% for 2004, and the figure for those living under the poverty line is close to 20% (2002 estimate). According to the CIA World Factbook on Jamaica, “the economy faces serious long-term problems: high interest rates; increased foreign competition; a pressured, sometimes sliding, exchange rate; a sizable merchandise trade deficit; large-scale unemployment; and a growing internal debt, the result of government bailouts to ailing sectors of the economy.”¹

The median age for Jamaica’s estimated population of 2,731,832 is 27.25 years with an estimated growth rate of 0.71 percent². The 2005 estimated life expectancy at birth is 71.63 for males and 75.12 for females. Current estimated infant mortality rates are 13.35 deaths/1,000 live births for males and 11.32 for females. During the period of 1998 to 2002, the total government expenditure on health as a percentage of gross domestic product (GDP) fluctuated between 5.5 and 6.4 percent and the Government expenditure on health as a percentage of total government spending ranged from a low of 4.3 in 2001 to a high of 6.6 in 2000.³

According to the National HIV/STD Prevention and Control Program’s most recent surveillance report, “Facts and Figures on HIV/AIDS Epidemic Update”, which was released in June 2005, the following statistics were gathered for the period of January to December 2004:

- The number of reported AIDS cases in Jamaica was 1,112 (603 males and 509 females).
- The rate of reported AIDS cases in Jamaica showed a 3.9% increase in 2004 compared to the same period in 2003.
- There were 665 AIDS deaths in 2004 compared to 650 AIDS deaths in the previous year. A relatively small increase (2.3%) compared to the previous year.
- In Jamaica, one out of three persons with advanced stage of HIV infection have access to ARV therapy
- There were 1,112 new cases of AIDS, 54.2% male and 45.8% female. This figure has steadily increased since the year 2000 when 903 new cases were reported although the rate of growth between 2003 and 2004 showed a significant decline.

¹ CIA – The World Factbook. Updated November 2005. Retrieved December 1, 2005 from <http://www.cia.gov/cia/publications/factbook/geos/jm.html>

² *ibid*

³ World Health Organization – Country Health Indicators. Retrieved December 1, 2005 from <http://www3.who.int/whosis/country/indicators.cfm?country=JAM&language=english>

SUMMARY OF AIDS CASES IN JAMAICA

PERIOD	TOTAL	MALE (%)	FEMALE (%)
Cumulative 1982-2004	9209	5428 (58.9)	3781 (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)

On November 23, 2005, Dr. Peter Figueroa, Senior Medical Officer with the National HIV/STI Prevention and Control Programme (also known as the National AIDS Programme or NAP) announced at the Annual General Meeting of the National AIDS Committee (NAC), a civil society umbrella organisation, that 22,000 Jamaicans are currently estimated to be living with HIV but approximately two-thirds do not know their status. He further stated that the rate of infection has remained nearly steady over the past year indicating that progress had been made in curtailing the spread of HIV but that the current efforts have not yet resulted in the desired decrease in new infections. According to Dr. Nesha Z. Haniff, in Jamaica, "HIV/AIDS incidence is calculated on AIDS records rather than HIV infection, that is the numbers reported are more or less about people whose CD4 counts are 240 or less."⁴ With this in mind, the adult HIV prevalence rate at the end of 2003 was estimated at 1.2 percent.⁵ In Jamaica, high-risk populations include "commercial sex workers (10-20% prevalence); men who have sex with other men (25% prevalence), prison inmates (12% prevalence) and persons with past exposure to sexually transmitted infections (6% prevalence)".⁶

⁴ HIV/AIDS in Jamaica: The Current State with Special Attention to Marginalized Groups. Nesha Z. Haniff. Unpublished manuscript, August 10, 2005.

⁵ UNICEF – At a Glance: Jamaica. Retrieved December 1, 2005 from http://www.unicef.org/infobycountry/jamaica_statistics.html#7

⁶ The Jamaica National HIV/STI Control Programme. Retrieved November 30, 2005 from http://www.jamaica-nap.org/prog_i.html

<p style="text-align: center;">SECTION 3 BACKGROUND General Overview of the Response to HIV/AIDS in Jamaica</p>
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PART 1: Government Response

The Jamaican Charter of Rights and Freedoms does not include a specific right to health; however, listed first is the right to “life, liberty and security of the person”. Under this Charter, various laws have been adopted that impact on HIV/AIDS reduction efforts, including the Offences Against the Persons Act of 1864. While not technically making homosexuality illegal, the Act outlaws “the abominable act of buggery” and “acts of gross indecency” (as may be determined by the courts based on prevailing community standards) and punishable by up to 10 years of “hard labour”. In other legislation, transactional sex and illicit drug use are also illegal. In recent years, various public figures, including Parliamentary committees and the Senior Medical Officer with the National AIDS Programme, have called for repeal of buggery laws and legalisation of commercial sex work. In addition, a concerted effort is currently under way to pass laws protecting PLWHA from discrimination.

As a department within the Ministry of Health, the National AIDS Programme “coordinates the prevention, treatment and control of HIV/AIDS and other Sexually Transmitted Infections in Jamaica.”⁷ This programme includes the following components:

1. Behaviour Change Communication (BCC) Programmes
2. Laboratory Services
3. Research
4. STI Control and Prevention
5. HIV/STI Surveillance
6. Treatment Care and Support
7. Capacity Building
8. Policy and Planning
9. Monitoring and Evaluation
10. Voluntary Confidential Counselling and Testing (VCCT)
11. prevention of mother to child transmission (MTCT)
12. Condom Promotion
13. Training
14. Liaison with regional and international bodies such as CAREC, UN agencies & UNAIDS

In addition, a subcomponent of the National AIDS Programme, the HIV/AIDS Demand Driven Sub-Project (HADDs), facilitates the involvement of non-governmental organisations, faith based organisations and community based organisations through funding for specific projects they have

⁷ Jamaica Ministry of Health. Retrieved November 30, 2005 from: http://www.moh.gov.jm/HIV_AIDS.html

identified in their respective areas of work. The National AIDS Programme (NAP) has conducted numerous policy and programme development meetings with key stakeholders. The NAP maintains a comprehensive monitoring and evaluation effort that includes 104 global and/or national indicators in the following areas:

- 1) HIV/AIDS/STI Impact
- 2) Behaviour Change Communication: Knowledge, Attitudes and Behavioural Outcomes
- 3) Voluntary Counselling and Testing Services
- 4) Orphans and Vulnerable Children
- 5) Prevention of Mother To Child Transmission
- 6) Condom Marketing and Distribution
- 7) Policy, Advocacy and Human Rights
- 8) Blood Safety
- 9) Treatment, Care and Support
- 10) Post Exposure Prophylaxis
- 11) Stigma and Discrimination
- 12) Monitoring and Evaluation Strengthening
- 13) Multi-sectorial Response
- 14) National Commitment

Developed by the National AIDS Programme, the Jamaica HIV/AIDS/STI National Strategic Plan 2002-2006 outlines a national, comprehensive and multi-sectorial response to the epidemic. It listed the following five priority areas:

PRIORITY AREA 1 - Policy, Advocacy, Legal and Human Rights

<i>OBJECTIVE</i>	<i>STRATEGIES</i>
1. To protect and promote the legal, ethical and human rights of people living with HIV/AIDS.	<ul style="list-style-type: none"> • Ensure access to education, employment health care and social services. • Enact, strengthen, or enforce as appropriate legislative and other measures to eliminate discrimination against PLWHA • Involve people with HIV/AIDS and AIDS service organizations in the design, implementation and evaluation of HIV prevention programme. • Train health care workers in ethics related to HIV/AIDS.
2. To reduce human rights abuses and discrimination against PLWHA.	<ul style="list-style-type: none"> • Monitor and report cases. • Support the infrastructure required to gather and analyze information. • Design, develop and implement education programmes that dispel stigmatization and myths. • Educate youth and children to reduce stigma and discrimination.
3. To Strengthen capacity of organizations to work in the area of advocacy.	<ul style="list-style-type: none"> • Training and capacity building in advocacy techniques. • Organizational strengthening for advocacy, including computers and technical assistance

PRIORITY AREA 2 - Multi-sectorial Response

<i>RESPONSIBLE AGENCY</i>	<i>ACTIVITY</i>	<i>TARGET POPULATION</i>
1. MINISTRY OF HEALTH	<ul style="list-style-type: none"> ● Prevention of MTCT. ● Voluntary Confidential Testing and Counselling. ● Behaviour Change Communication and Intervention. ● Care Treatment (hospital, outpatient care). ● Training of health care workers. ● HIV/STI surveillance. ● Blood supply protection. ● Improve the infrastructure in health and social facilities. ● Re-organization of service delivery and partnership. ● Assessment and improved logistical management of basic medicines. 	<ul style="list-style-type: none"> ● Pregnant women and women aged 15-49 years. ● Men and women aged 15-49 years. ● See target population under 2b page 13. ● PLWHA. ● Health care workers in public and private sectors. ● Physicians and nurses.
2. MINISTRY OF EDUCATION, YOUTH AND CULTURE	<ul style="list-style-type: none"> ● Develop School policy on HIV/AIDS. ● Health and Family Life Education including education on sex and sexuality, HIV/AIDS and other STI. ● Review curricula to include HIV/AIDS in teachers training colleges. ● Develop and implement national strategy of peer counselling. ● Promote youth friendly services and centres. ● Expand counselling services in reproductive health. ● Public education. ● Develop resource material for textbooks, reading and education including low literacy. ● Specific media spots and 	<ul style="list-style-type: none"> ● Staff and Students ● School children and adolescents ● Teachers and guidance counsellors ● Youth including those out of school ● Counsellors, education officers, youth and parents ● School children and school community ● Writers and Trainers ● School children

	messages to schoolchildren.	
3. NATIONAL AIDS COMMITTEE	<ul style="list-style-type: none"> Advise the Nation on HIV/AIDS policy and mobilize resources for grass root organizations and PACs. Advocate for and monitor the human rights issues of PLWHA. Monitor sectorial activities. 	<ul style="list-style-type: none"> National Planning Council, Ministry of Health, general population, private sector, donor organizations. General Population Legislators Private sectors and NGOs
4. MINISTRY OF TOURISM	<ul style="list-style-type: none"> Policy guidelines for prevention and HIV/AIDS education and activities at tourist facilities including access to condoms. Production of educational materials for use in the sector. Develop core of peer educators and trainers for team Jamaica. HIV/AIDS awareness program and information dissemination. Liaise with the private sectors (hotels and tourism) in targeted interventions 	<ul style="list-style-type: none"> Tourism leaders, managers, workers, and clients. Community based tourism projects, team Jamaica hotel workers, trainers, attraction and entertainment venues operators. 70, 000 programme participants of team Jamaica. Workers in the hospitality industry. Hotel managers, workers, taxi operators, attractions operators, craft vendors. Employers in hospitality industry. Workers in the hotels, tourism, workers at ports of entry and taxi operators Tour guides and operators
5. MINISTRY OF LABOUR AND SOCIAL SECURITY	<ul style="list-style-type: none"> Promote monitor the development of comprehensive workplace Policy and interventions. Support the education programmes in all government ministries. Collaborate with employers and trade unions to implement workplace programmes. Support educational campaign through the 	<ul style="list-style-type: none"> All workplaces Employees of government ministries and industrial health and safety divisions, unions. Employees in private sector Sports men and women General population

	<p>involvement of sport personalities and national teams.</p> <ul style="list-style-type: none"> • Educate all at risk persons because of their jobs and movement. • Support Mother to Child transmission prevention redefining social services. • Care and support services access to limited benefit programs through food stamp, and poor relief 	<ul style="list-style-type: none"> • Migrant workers overseas. • At risk women and children.
6. MINISTRY OF NATIONAL SECURITY AND JUSTICE	<ul style="list-style-type: none"> • Provide information and education • Develop policy on HIV/AIDS • Collaborate with NGO in educational and care programmes • Train police officers in biosafety 	<ul style="list-style-type: none"> • Members of Jamaica Constabulary and Jamaica Defence Force • Correctional Services Staff • Prisoners • Police officers.
7. JAMAICA INFORMATION SERVICES	<ul style="list-style-type: none"> • Production of mass media campaigns and information materials in collaboration and sponsorship of government ministries. 	<ul style="list-style-type: none"> • General population • Media professionals • Vulnerable groups. See target population under 2b page 13.
8. PRIVATE SECTOR ORGANIZATIONS	<ul style="list-style-type: none"> • Mobilize resources • Advocacy • Monitor planned intervention activities in the workplace • Develop workplace coalitions to direct private partnership • Participate in training of employees, and managers on HIV/AIDS • Provide support for workers with HIV/AIDS • Assist in developing family education and community outreach programme 	<ul style="list-style-type: none"> • General population • Labour force in private sector • Workers in private sector • Workers and their families in private sectors
9. FAITH BASED ORGANIZATIONS	<ul style="list-style-type: none"> • Support and care for PLWHA. • Combat discrimination 	<ul style="list-style-type: none"> • PLWHA • General population • PLWHA and families

	<ul style="list-style-type: none"> • Counselling for families and PLWHA • Train pastors in counselling skills • Educate members on HIV/AIDS • Mobilize resources 	<ul style="list-style-type: none"> • Pastors and counsellors • Church members
10. TRADE UNIONS , TRADE ASSOCIATION AND LABOUR ORGANIZATION	<ul style="list-style-type: none"> • Action programmes • Advocacy, support for the right against discrimination and inequalities of PLWHA • Conduct awareness campaign • Develop reproductive health program in their health services 	<ul style="list-style-type: none"> • Workers in the trade Employers and public sector • Workers • Workers and their families
11. NON GOVERNMENTAL AND COMMUNITY BASED ORGANIZATIONS	<ul style="list-style-type: none"> • Prevention activities Education in risk reduction, condom distributions to vulnerable groups. • Care, counselling and support for PLWHA and families • Advocacy for the human rights, against stigma and discrimination • Develop resource material for targeted groups 	<ul style="list-style-type: none"> • General population, high-risk groups such as MSM, CSW and Prisoners. • PLWHA and their families • Legislators, general public • See target population under 2b page 13.
12. UNAIDS THEME GROUP (PAHO/WHO, UNICEF, UNDP, UNFPA, UNESCO)	<ul style="list-style-type: none"> • Advocacy • Public information • Community involvement • Evaluation and monitoring of strategic plan • Research on determinants of the epidemic • Resource mobilization develop strategic alliance 	<ul style="list-style-type: none"> • Political leaders • Public • PLWHA • NSP • Universities, NAP • International donors, pharmaceuticals
13. PLANNING INSTITUTE OF JAMAICA	<ul style="list-style-type: none"> • Monitor the national response • Evaluate the activities of different government ministries • Study the social and economic impact of HIV/AIDS in Jamaica 	<ul style="list-style-type: none"> • Governmental ministries and bilateral multilateral agencies

	<ul style="list-style-type: none"> • Co-ordinate the activities and resources of international donors 	
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PRIORITY AREA 3 - Prevention

<i>OBJECTIVES</i>	<i>STRATEGIES</i>
1. To Reduce HIV Mother to Child Transmission	<ul style="list-style-type: none"> • Expansions of the pilot MTCT prevention program to all parishes • Provide VCCT of all pregnant women • Train all relevant health care workers in MTCT. • Develop VCT sites • Integrate MTCT into the existing reproductive health services
2. To promote and increase effective and culturally appropriate safe and healthy responsible sexual behaviour attitude and practice.	<ul style="list-style-type: none"> • Increase access for teen friendly reproductive health services • Train peer educators • Develop age appropriate educational materials
3. To increase effective targeted intervention aimed at high risk behaviour and socially marginalized groups	<ul style="list-style-type: none"> • Train peer educators • Develop materials
4. To expand Voluntary Confidential Testing and Counselling	<ul style="list-style-type: none"> • Improve facilities • Train counsellors • Introduce counselling services in other facilities • Use rapid HIV test • Workplaces counselling
5. To reduce the incidence and prevalence of STI through effective diagnosis and treatment.	<ul style="list-style-type: none"> • Prompt and effective management of STI in both private and public health facilities. • Ensure adequate supply and effective distribution of drugs • Increase health seeking behaviour of STI patients
6. Condom Social Marketing and Promotion	<ul style="list-style-type: none"> • Ensure availability and affordability of condoms
7. To maintain safe blood transfusion services	<ul style="list-style-type: none"> • review and amend national blood transfusions services policy • Continue to implement practices for monitoring and ensuring safe blood supply
8. Post exposure Prophylaxis	<ul style="list-style-type: none"> • Develop PEP management clinical guidelines • Train health care workers in effective medical waste management • Reduce predisposing factors in Occupational exposure to HIV

PRIORITY AREA 4 - Care, Treatment and Support

<i>OBJECTIVES</i>	<i>STRATEGIES</i>
1. Increased access and improved care, treatment and support to people living with HIV/AIDS	<ul style="list-style-type: none"> • Define basic drug package • Develop treatment guidelines

	<ul style="list-style-type: none"> Collaborate with pharmaceutical companies and agencies to reduce the cost of anti AIDS drugs
2. Reduce the morbidity and mortality of PLWHA through implementation of comprehensive care programme	<ul style="list-style-type: none"> Establish regional treatment sites Develop community and home based care network
3. Develop and expand care and support for orphans and children made vulnerable by HIV/AIDS	<ul style="list-style-type: none"> expand community based care for OVC collaboration with NGO/CBO Reduce stigma and discrimination through education

PRIORITY AREA 5 - Surveillance, Monitoring and Evaluation

<i>OBJECTIVES</i>	<i>STRATEGIES</i>
1. To understand the trends of HIV/AIDS overtime and the behaviour driving the epidemic and plan targeted intervention	<ul style="list-style-type: none"> Monitor the national epidemiological data collection to ensure that future data Educate the public on the purpose and importance of gathering HIV/AIDS related epidemiological data. Conduct periodic HIV sero surveys in selected groups., i.e., ANC, STD clinic attendees Conduct behavioural and biological research
2. To improve the quality and effectiveness of STI and HIV prevention programme	<ul style="list-style-type: none"> Testing of groups of people or clusters of groups which could stand as proxy for the general population Testing to be done with the results linkable to individuals To use and maintain a high standard and quality test kits and testing algorithm. Expand and fully computerize STI reporting system Identify collaborative strategies to target and monitor private practitioners, pharmacist and medical representatives

As stated in the Plan, “Some priority areas were divided into sub sections and objectives and strategies were developed for each.” These were outlined in the following four “Outputs”:

- 1) An effective multi-sectorial response to the HIV/AIDS/STI epidemic focusing on:
 - a) Development and dissemination of sectorial HIV/AIDS/STI policy and sectorial plans
 - b) Strengthened Monitoring and Evaluation capacity
 - c) A legal and policy framework protective of the human rights of PLWHA and people affected by the HIV epidemic with attention to:
 - i) Policy and Legislative Environment
 - ii) Advocacy
 - iii) Stigma and Discrimination
- 2) Reduced individual vulnerability to HIV infection through behavioural change focusing on:
 - a) Affordable condoms accessible to sexually active men, women and young persons
 - b) Effective BCC programme with the following target groups and settings:

- i) Primary vulnerable groups:
 - (1) Girls 15-19 years, particularly in transactional or coercive relationships
 - (2) Sex workers
 - (3) Males 30-45 years (condom non-users) and their partners
 - (4) Men having sex with men, bisexuals and their partners
 - (5) Persons Living With HIV/AIDS and partners
 - (6) Persons with STIs and partners
- ii) Secondary vulnerable groups:
 - (1) Prisoners/ incarcerated population
 - (2) Clients of sex workers
 - (3) Drug users
 - (4) Young people in the inner cities
 - (5) Youth 15-24
- iii) Key Intervention Settings:
 - (1) Workplaces
 - (2) Schools
 - (3) Tourism
 - (4) Communities
 - (5) Prisons
 - (6) Institutions (uniformed population)
- 3) Reduced transmission of new HIV infection focusing on:
 - a) Prevention of Mother To Child Transmission
 - b) Improved STI Prevention and Control
 - c) Safe blood transfusion service
 - d) Post-exposure prophylaxis (PEP) for health care workers
- 4) Improved care, support and treatment services for PLWHA focusing on:
 - a) Improved quality of and access to VCCT
 - b) Improved access to and quality of care and support for persons infected with or affected by HIV by:
 - i) Enhancing the capacity of persons living with HIV to access highest quality of care that they can afford
 - ii) Enhancing the capacity of private sector and NGOs to provide care and support services to children orphaned and made vulnerable by HIV/AIDS
 - iii) Enhancing the national capacity for screening and diagnostics services for HIV/AIDS
 - iv) Strengthening the national capacities to provide effective counselling psychological and social support to persons living with HIV/AIDS and those affected by the disease
 - v) Developing and expanding the provision of specialized clinical care and social support to children vulnerable and orphaned by HIV/AIDS

- vi) Promoting and enhancing the capacity of communities to develop care and support networks for persons living with and affected by HIV/AIDS including day-care and hospice
- vii) Improving access to antiretroviral medications in public and private health facilities
- viii) Developing and disseminating guidelines and standards for the treatment and care of Persons Living with HIV/AIDS
- ix) Establishing a national basic standard package for care
- x) Establishing specialized treatment facilities in the regions
- xi) Developing and disseminating standards and guidelines for the safe and effective use of Antiretroviral Therapy (ART)
- xii) Identifying and strengthening the capacity of national organizations to provide comprehensive care and support for PLWHA
- xiii) Fostering and supporting collaboration and partnership with drug manufacturers, multilateral agencies and distributors nationally, regionally and internationally to secure high quality low cost anti-AIDS drugs, perhaps through the linkages of access to treatment with participation in research initiatives
- xiv) Designing and implementing the provision of a basic social benefit package for PLWHA in need, and support families to provide home based care

The National Strategic Plan also includes workplans for “lead agencies” including The Ministry of Education, Youth and Culture, The Ministry of Local Government, The Ministry of Labour and Social Security, The Ministry of National Security and Justice, The Ministry of Tourism & Sport. Each of these workplans has its own Ministry-specific objects with accompanying strategies and activities for implementation.

The National Strategic Plan was developed through a series of meetings that included members of various government agencies and civil society representatives from the sectors listed in Priority Area 2, above.

Although no specific prevention or treatment guidelines are included in this plan, subsequent policy documents provide these guidelines. In addition, no specific legislation supports the plan, but efforts are underway to have anti-discrimination laws in place within three years.

The per capita health spending by the government for 2002 was US\$103 and the government expenditure on health as a percent of total general government expenditure for the same year was 5.9%. Expenditures for previous years were 4.3% for 2001, 6.6% for 2000, 5.6% for 1999, and 7.4% for 1998.⁸ Additional budget information remains unavailable despite repeated efforts to

⁸ CIA – The World Factbook. Updated November 2005. Retrieved December 1, 2005 from <http://www.cia.gov/cia/publications/factbook/geos/jm.html>

acquire data from both the Ministry of Finance and the Ministry of Health. As a reference, the national income per capita for 2004 was US\$2,937.26.⁹

⁹ Statistical Institute of Jamaica. Retrieved on December 5, 2005 from <http://www.statinja.com/table-gdp.html>

PART II: Civil Society Involvement and Mobilization

In fulfilment of DoC paragraph 37, the Jamaica HIV/AIDS/STI National Strategic Plan (2002-2006) was drafted in 2001 with revisions in January 2002. In order to develop this plan, the National HIV/STI Control Programme solicited input from a variety of civil society actors (CSAs) through informal dialogues, meetings and focus groups. Progress reports and review drafts were distributed to some CS contributors through email, but this method limited the involvement of those without convenient email access. Some CSAs considered the process successful in representing their views (these were generally the larger agencies); others (typically PLWHA) felt that the government misinterpreted their input and forced them to “rubberstamp” approval. According to one such CSA,

“You usually get people who have not thought beyond their immediate selfish needs or those who maintain a measure of tolerance to get their indicator results.”

Some CSAs said they had no input into the process, though this may have been due to a turnover in staff or volunteers. The government supports some civil society implementation of the Plan in various ways including funding, capacity building training, and technical advice/training. Where it exists, this support was generally viewed as successful, though one CSA criticised the way funds were spent, believing that they went more toward administrative expenditures rather than direct services for PLWHA. This positive attitude was tempered, though, by CS criticism that many on-the-ground efforts suffered from a lack of resources and funding. According to one CSA, only 22% of funds available from the Global fund had been distributed. In addition, though funds from a World Bank loan and the Global Fund have allowed an increase in government support, a majority of International Development Partners (IDP) including the ILO, IDB, UNDP, UNFPA, UNICEF, UNESCO, USAID, CIDA, PAHO and JICA, expressed concern that these were not sustainable sources and that significant funding challenges lie ahead.

The National Programme conducts periodic reviews of its progress in implementing the National Strategic Plan and the National Policy. These reviews are often conducted in response to the requirements of funding entities, which do not necessarily correlate to DoC commitments but often overlap. A specific DoC review is currently being conducted with a completion date of December 31, 2005. These periodic reviews (which partially fulfil the goals of paragraph 94 of the DoC) include some (generally larger) civil society actors through their participation in the Global Fund Country Coordinating Mechanism (CCM), and various NAP committees such as the Monitoring and Evaluation and Policy committees. However, reliance on these groups limits the active participation of many smaller CSAs. As a result, uncertainty about the presence or purpose of the CCM and various committees, even the very existence of review activities, seems commonplace. Some CSAs are also involved in the review through their involvement with the National AIDS Committee, which disseminates information to members of its subcommittees. While this mechanism generally works well, CSAs who are not involved with the NAC (often due to their distance from Kingston where meetings are held, or limitations of staff or resources) find their access to information and input limited. One CSA offered the following:

“Perhaps there could be some level of monitoring of the agencies that make use of the [Jamaica HIV/AIDS National Strategic Plan]... and invite their participation in

decision-making and World AIDS Day and Human Rights Day. In this way, the expansion of participants could be observed over time as an indicator of project success; the allocation of website space to consolidate the multi-sectorial linkages is another option.”

Another CSA echoed this comment by suggesting greater utilisation of the MOH or NAC website to post current documents and solicit input with text messages to notify of new postings and a members only portion of the site to facilitate comments.

Few CSAs are aware of the UNGASS Declaration of Commitment and only one CSA claimed involvement in any national review of progress toward implementation of the commitments (this was in preparation for World AIDS Day 2005, which focused on the theme “Keeping the Promise”). No CSAs claimed use of the document as an advocacy tool. To rectify this situation, more CSAs need to be educated about the DoC and its implications. One CSA suggested:

“Copies of the DoC [should] be made available in every library and online throughout the island. “

Another suggested:

“More meetings convened with stakeholders at different times during the year with clear objectives of sharing information on the progress the country has made and areas we need to improve on.”

In fulfilment of paragraphs 49 and 69 of the DoC, the National HIV/STI Control Programme recently developed a National Workplace Policy in collaboration with “a tripartite team of government, employers and workers under the guidance of the Labour Advisory Committee” including the Jamaica Employers Federation (JEF), the Jamaica Confederation of Trade Unions (JCTU) and the National AIDS Committee (NAC).¹⁰ This policy utilises the International Labour Organisation’s ‘Code of Practice on HIV/AIDS and the World of Work’, which identifies ten key principles including non-discrimination, gender equality, no screening for exclusion, confidentiality, prevention, and care & support. During 2004, The NAP began distributing a “Toolkit” booklet, which includes an interactive PowerPoint file on CD. This toolkit provides general workforce education and helps businesses to create and implement internal HIV/AIDS policies. By the end of August 2005, the National Programme assisted twenty-eight private companies in developing and adopting HIV policies. In December 2005, USAID and a major international pharmaceutical company announced the creation of the Jamaica HIV/AIDS Business Council whose stated goal is to assist businesses in developing and implementing workplace policies. Despite this progress, several major employers, including some branches of government, still use HIV testing to exclude job applicants, and claims of workplace discrimination are common. As of now, efforts are underway to enact supportive legislation; however, this is several years away. Other private sector initiatives to address HIV/AIDS include a programme to provide small business loans to HIV+ individuals, and a commitment from several attorneys to provide free legal counsel for PLWHA who believe they have experienced discrimination. When

¹⁰ The Jamaica National HIV/STI Control Programme website. Retrieved December 6, 2005 from <http://www.jamaica-nap.org/news1.htm>

questioned, most CSA considered the workplace policy to be comprehensive but several saw deficiencies in the areas of workplace training (especially regarding stigma and discrimination) and enforceable sanctions for those who breach policies. One CSA had this to say:

“There is a need to recognise HIV/AIDS as among the sexual reproductive health consequence of sexual violence including sexual harassment. This is to be addressed within the rubric of sustainable terms and conditions of work, which entails a transparent and user-friendly institutional access to remedies to address violence at the workplace. The fact that the status of your sexual health represents a discriminatory barrier presupposes a level of sexual readiness as a prerequisite for workforce participation. This is a problem when productivity is the bottom line and the exigencies of reproduction translate into an opportunity cost for women and men as workers. There is a clear violation of human rights that need to be safeguarded, which the HIV/AIDS policy embodies in principle; a principle [that] needs to be made less implicit.”

Another commented:

“[The workplace policy] has been widely disseminated; it isn’t enforced.”

The general attitude of most CSAs is that the policy is good, but enforcement is the critical standard by which success should be measured and in this regard, much progress remains in changing workplace attitudes and behaviours.

Civil society actors are routinely involved in assisting the government in its commitment to implement prevention programmes (DoC paragraphs 18 and 52). Various actors, as well as government run facilities and outreach programmes, distribute free condoms and, to a lesser degree, lubricants. NGOs receive condoms from the Ministry of Health for distribution. Most NGOs, CBOs and FBOs operating in this arena conduct HIV education activities of one kind or another. For example, several agencies conduct educational programmes where PLWHAs or MSMs provide “living testimonies” of their lives (however, although this provides an income for the speakers, concern has been raised about the lack of psychological support provided for those who reveal such private information about themselves.) Other organisations engage in “edutainment” productions geared toward youth audiences. The Ministry of Health (MOH) provides funding and/or training for some of these projects. The MOH also funds and directly manages a public awareness campaign that includes radio, television, and newspaper advertisements. It also funds the distribution of posters and brochures door-to-door to the general public, to government clinics, and to NGOs, CBOs and FBOs. Civil society actors are also involved in conducting voluntary counselling and testing services (see the VCT discussion below).

The Government efforts to increase access to treatment (DoC paragraphs 15, 24, 25, 26, and 55) received an important boost in 2004 from the Global Fund grant that allocated approximately 70% of the US\$23.318 million toward this effort. The multi-sectorial Country Coordinating Mechanism set the following three objectives for this component of the project: 1) improve the availability and quality of monitoring and diagnostic services for PLWHA of all ages, 2) island-wide provision of adherence counselling and psychological support, and 3) provide anti-retroviral therapy to PLWHA of all ages. Civil society actors participated in the development of these objectives

through stakeholder meetings, and they continue to make contributions through the Treatment Working Group, which includes PLWHAs and NGOs. In the effort to achieve these objectives, the government recently acquired the equipment necessary for local testing of CD4 and viral load counts. It has also introduced rapid testing at a limited number of sites. Training of healthcare workers in both the public and private sector continues according to set targets. Civil society actors assist in the effort to improve treatment access by providing medical assessments or referrals, supplying non-prescription drugs, paying for transportations costs, medical bills and other treatment expenses, making home visits and training families on how to care for PLWHAs, and performing emergency interventions to assist those in critical need of medical care. A number of CSAs participate in the MOH Treatment Task Force where they advocate for specific treatment policies and programmes. No CSA claimed to operate an adversarial advocacy campaign; however, strident voices for improved treatment do exist, especially in the PLWHA network, and the MOH seems willing to address their concerns, at least in policy. The major impediments to treatment appear to lie in delays and inefficiencies in lab testing. The MOH has made efforts to address these deficiencies with greater use of rapid testing for HIV, and acquisition of new testing equipment. Unfortunately, it seems there is still considerable room for improvement in this area.

Civil society actors provide a considerable portion of the overall care and support services available to PLWHAs (DoC paragraphs 56 and 57). This involvement began in the planning phase with CSA input into the development of policies and strategies through workshops and planning meetings. The CSAs provide a wide range of services including counselling, home-based care, hospice care, distribution of medical, food, clothing and other supplies (including holiday gifts), crisis interventions, and a very limited amount of hospice care. Some of these efforts are funded by the Government especially through the Global Fund grant (see Objective 2 in previous paragraph).

The Government has made efforts to involve CSAs in interventions to address the specific needs and rights of women and girls in its national response to HIV/AIDS. Various stakeholders were involved in policy development and, to a lesser degree, project implementation. The most visible government projects involve media campaigns (print, radio and television) that provide gender specific messages about HIV/AIDS prevention (both primary and mother to child) and testing. Projects carried out by CSAs include personal and professional development programmes, condom distribution activities, and efforts to strengthen condom negotiation skills. Despite claims of gains made by women in some spheres (most notably education), cultural norms still foster gender inequities that make sexual autonomy, including condom negotiation, difficult, especially for teenage girls who show much higher rates of AIDS diagnosis than boys in the same age range. In addition, poverty and unemployment still affect women much more severely than men.

Several CSAs work to protect the rights of PLWHAs and vulnerable groups in varying capacities and in some instances with the assistance of the Government (DoC paragraphs 13, 58 and 96). Two of the national NGOs specifically monitor for discrimination against PLWHAs and one of these (along with a human rights NGO) monitors for abuses against MSM. In one of these cases, the MOH is providing training and technical assistance. All of these agencies and many others

provide prevention services (directly or indirectly) to these groups and to sex workers and persons in legal confinement through education, condom distribution, referrals and crisis interventions, often with Government financial assistance. These groups also reinforce the anti-discrimination message of Government media campaigns and policies through their own outreach efforts and radio broadcasts. The success of efforts to protect human rights for these groups is uncertain. Reports of discrimination, especially against PLWHA and MSM, abound, yet only one legal case has been identified that addresses this situation (a case of anti-gay violence is slowly working its way through the courts). Reasons given for this include fear on the part of victims to come forward due to the potential for increased discrimination or violence, disinterested or even abusive law enforcement, and an insensitive media. Since these problems stem from deep seated cultural, religious and political norms (particularly in the case of MSM), solutions are complex. CSAs have called for greater education, political leadership (to reduce poverty, repeal discriminatory laws, and provide legal protections), and religious tolerance. With civil society prodding and cooperation, some movement has been made in this direction. Government officials have called for legal reforms (much to the public's outrage in the case of repealing the 'Buggery Law'), some members of the legal fraternity have been 'sensitised' to the issues 14 have volunteered to provide free legal assistance in discrimination cases, the head of the Constabulary Force has agreed to assign a liaison to the LGBT community and to introduce sensitivity training to new officers, and efforts are underway to pass a Non-Discrimination Act for PLWHA.

A large portion of prevention efforts by CSAs is focused on reducing the risk of HIV transmission to youth (paragraphs 53 and 63 of the DoC). Peer education programs are sponsored by several agencies, as are classroom outreach efforts, character development oriented curricula, recording 'living testimonies', and 'edutainment' programmes. Age specific educational materials and programmes have been developed by CSAs often with assistance from the Government. CSAs were also involved in the development of a schools policy for the Ministry of Education, Youth and Culture. However, one agency heavily involved in this arena believed that a greater reliance on the ABC approach was needed. Some of the criticisms of Government efforts in this area include difficulty in securing government funding due to a lengthy application process, lack of sustainability of programs, and uncertainty over the effectiveness of lobbying efforts.

Efforts to assist children orphaned or infected by HIV/AIDS received the greatest amount of criticism from CSAs. In fact, a highly critical report published in 2003 by a civil society human rights organisation highlights neglect and abuse (including sexual abuse) at government-funded sites. Recent updates indicate that there has been little improvement. Although a number of CSAs offer assistance to these children such as food, clothing, and information, there was general consensus that government attention and funding devoted to this issue was insufficient to address discrimination, cover basic needs, and provide for medical and psychological needs. A lack of accountability for the existing funds and humane treatment of these children was also seen as a problem. Recommendations include increased funding, faster rollout of programmes, more advocacy and education on stigma and discrimination, and greater oversight and accountability by both the government and the caregivers.

SECTION 4 NATIONAL HIV/AIDS POLICY AND ITS IMPLEMENTATION
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PART I: Access to Treatment, Care and Support (DoC paragraph 15, 24, 25, 26, 55)

The National AIDS Policy, an output of Jamaica HIV/AIDS/STI National Strategic Plan 2002-2006, calls for improved treatment and care of PLWHA. Through resources provided largely by the Global Fund, access to ARVs, development of a support system to ensure adherence to the drug regimen, nutritional interventions, prophylaxis and treatment of opportunistic infections and other symptoms, and palliative care including home-based and hospice care was enhanced. Other funding sources provided support for the development of medical management guidelines and continuous training of healthcare providers. These guidelines call for a combination ARV approach known as the Highly Active Antiretroviral Therapy (HAART) regime where 3 drugs are used in various combinations. The following drugs are approved for this therapy: Zidovudine, Lamivudine, Stavudine, Efavirenz, Nevirapine, Indinavir, Didanosine, Nelfinavir, Lopinavir, and Ritonavir. The Jamaican Vital, Essential and Necessary Drug List includes all of these with the exception of Lopinavir. It also includes Abacazir, which is not on the approved drug list provided by the National HIV/STI Control Programme. These drugs are available in generic form from several pharmaceutical supply companies that provide them to pharmacies and the MOH.

Patients receiving private treatment pay approximately US\$700.00 per month for this therapy, whereas clients at government facilities are asked to pay a nominal fee of approximately US\$17.00 with provisions in place to provide the drugs free of cost for those who cannot afford the fee. This fee will ostensibly be used to help subsidize future cost of providing drugs once the Global Fund monies have expired. The process for obtaining free drugs deters some who feel shame and stigma by acknowledging their inadequate financial situation. A card system has been proposed to lessen this effect but has not yet been implemented. Adults are eligible for ARV therapy when any of the following criteria have been met: 1) they have received a clinical diagnosis of AIDS, 2) they have a CD4 count of 200 or less, 3) they have a lymphocyte count between 1200 and 1400/mm³, or 4) have CD4 counts between 200 and 350 with other clinical features. According to the Ministry of Health report to the Global Fund for the quarter ending on August 31, 2005, 1,246 adults and 141 children with advanced HIV were receiving ARV treatment. By the same date, there were twenty-two private sector ARV distribution sites (including six drug-serv pharmacies), eighteen public sector treatment sites with adherence counselling, and forty-two private practitioner treatment sites with adherence counselling. Currently, approximately 2,200 individuals receive ARV treatment out of an estimated 3,600 in need. These numbers are consistent with quarterly targets established in the Global Fund proposal.

Despite major media campaigns, stigma and discrimination still discourage HIV+ individuals from being tested and/or accessing treatment. Stories of people being fired or removed from school are common among CSAs despite Government claims that these stories cannot be substantiated by legal cases. Groups with double stigmas, especially MSM and CWS, find these fears especially

paralysing. Adding to the fear are legitimate concerns about the degree of confidentiality. Policies on paper do not always translate into clear understanding of procedures and/or proper behaviour by healthcare workers. Fears about confidentiality discourage many HIV+ Jamaicans from seeking testing and treatment until their health has deteriorated to the point that they are forced to seek medical attention.

Treatment-literacy trainings have been conducted by the MOH for both practitioners and PLWHA. According to Global Fund reporting for the quarter ending August 31, 2005, a total of 124 healthcare workers and 18 PLWHAs have received adherence counselling and psychological support during the 15 months of the project.

The Ministry of Health identified the following barriers to expanding these services: 1) procurement problems, 2) human resource limitations, and 3) general lack within the health sector. Despite Government efforts to recruit, train and retain healthcare personnel, most facilities require staff to work long hours at substantially less than their counterparts in developed countries. As a result, many Jamaican healthcare workers seek better living conditions overseas.

Persons Living with HIV/AIDS

Reports from persons living with HIV/AIDS vary considerably. Shame related to seropositive status discourages many Jamaicans from seeking treatment. This disease is still judged extremely negatively by many Jamaicans. It also is often linked to homosexuality, which carries even greater negative judgment by many. Another very common deterrent to treatment is the fear that ones HIV status will not remain confidential. Stories of inappropriate use of medical information abound, whether in a medical, work or school setting. None-the-less, many Jamaicans are receiving ARV treatments now that the cost at Government clinics has been subsidised by the Global Fund grant. Most in treatment consider the requested fee of J\$1,000.00 with provisions for free access to be reasonable and manageable. Many others, though, have complained about the fee system and report quite judgmental attitudes on the part of clinic staff who assist those seeking a waiver from payments. For some, merely asking for special financial consideration can be a shameful experience.

When it comes to other treatments, access declines due to financial constraints. Other than a single antibiotic, whose cost is covered by the Government, other medications and medical fees are the responsibility of the patient. This results in many people avoiding treatment for opportunistic infections until they become critical. At this point, most are admitted to hospital where their medical needs are addressed and the bill, which still remains the responsibility of the patient, can be ignored without fear of recrimination.

Due to financial constraints, the vast majority of PLWHAs who seek treatment do so at designated Government health centres and hospitals. These are distributed throughout the island but may not be in close proximity to some patients. As a result, transportation costs can become prohibitive.

Some agencies provide limited assistance with this problem, though resources are scarce for such assistance. Drugs can be accessed at the treatment sites or from a limited number of pharmacies. Some agencies have made arrangements with pharmacies to pay for and deliver drugs to patients who are unable or unwilling to obtain them in person. The MOH conducts ongoing adherence counselling and support with a portion of those on ARV therapy but this effort could be enhanced considerably. Psychosocial care is also available, but PLWHAs report that more is needed.

PART II: Prevention (DoC paragraph 17, 18, 47, 49, 50, 52, 53)

As mentioned earlier, the National Strategic Plan identifies prevention as one of its five priority areas. The plan lists eight prevention objectives within this priority area including: increase condom use, promote responsible sexual behaviour, increase interventions targeting high-risk behaviour and socially marginalized groups, expand VCT, reduce mother-to-child transmission, reduce incidence and prevalence of STIs through effective diagnosis and treatment, maintain safe blood transfusion services, provide post-exposure prophylaxis. Varying degrees of progress have been made in each of these areas.

Civil society actors report that the type and availability of prevention tools is quite variable. Male condoms are widely available throughout Jamaica at pharmacies (both independent and those within retail stores), NGO's and non-traditional locations such as vending machines at racetracks, universities, and tourist locations.¹¹ Due to their much higher cost, female condoms are available at some pharmacies, a few adult specialty stores in urban centres, and occasionally at NGO distributions sites. The same is true for water-based lubricants though they are more widely available at pharmacies. Oral dams are available at a very limited number of pharmacies, but rubber gloves, which can be substituted (with consumer modification), are readily accessible. Bleach is very widely available but injecting drug use is very low due to cultural conditioning so its use in needle disinfection is virtually unheard of. Availability of clean needles is likewise of minor importance in HIV prevention in Jamaica. Since the National Strategic Plan calls for increased availability of condoms, this objective along with lubricant distribution is tracked for Global Fund reporting.

Educational and behaviour change material related to the prevention of HIV is provided to the public by programmes supported by the MOH and CSAs. These are conducted at schools, churches, informal gatherings, PTA meetings and other group meetings, employee workshops, commemorative events, street outreach activities, community and commercial events, and similar gatherings. A Government run media campaign also provides information through the distribution of brochures, posters and flyers in addition to public service announcements and "mini-dramas" aired on television and radio. The MOH was not forthcoming in providing information about the frequency of these announcements, but they seem to vary with more in early December and in mid February to coincide with World AIDS Day and Safer Sex Week. In all cases, the messages may be general or audience specific and sometimes include PLWHA providing "living testimonies". The MOH has developed specific prevention messages for young people, women in general, pregnant women, and nursing mothers. Noticeably absent are any messages targeting MSMs or SWs. The main prevention messages vary depending on who is providing the message and the target audience. Faith-based organisations and those of a religious persuasion tend to advocate abstinence and fidelity, with condom use sometimes included when a risk assessment warrants.

¹¹ In addition, as part of the PLACE (Priority for Local AIDS Control Efforts) Project, a randomized, controlled study is being conducted in which the effectiveness of condom vending machines are being studied at 76 designated sites.

This is also true for many schools where complaints from parents, prevailing standards or the attitudes of teachers or guidance counsellors who provide sex education may result in a lack of education about condom use. Other, more secular educators advocate abstinence, fidelity, reducing the number of partners, and consistent, proper condom use.



In keeping with the objectives of the National Strategic Plan, the National HIV/AIDS Policy specifically mentions the “need to intensify prevention interventions among those at risk including most vulnerable populations such as persons living with HIV/AIDS (and their partners), commercial sex workers (CSW), and men who have sex with men (MSM).” Under the heading of “Rights and Responsibilities of Stakeholders”, street and working children and inmates (in addition to adolescents and youth, commercial sex workers, and men who have sex with men) are also listed as “most vulnerable groups” with specific rights and needs, but they are not mentioned in any specific prevention efforts. However, not all vulnerable groups are being identified. For example, one CSA claims:

“The UN Theme group on HIV/AIDS in Jamaica reports that in 2003 there was a 33% increase in the reported AIDS cases registered in persons over the age of 60 years. There is no intervention targeted at this stage of the lifecycle owing to stigma and discrimination of the older adult cohort as nonsexual beings.”

In addition, refugees and injecting drug users were not mentioned in the National Policy, possibly because their few numbers were deemed insignificant. Based on information provided by the MOH (or lack thereof), it is unclear whether these vulnerable groups have been prioritized for prevention efforts.

The National Policy also addresses the need to reduce HIV/AIDS related stigma and discrimination. This has been addressed through media campaigns, assistance with “living testimonies” from PLWHAs, and efforts to educate leaders in the business sector as well as their employees. Unfortunately, most CSAs and international development partners report that stigma and discrimination remain the greatest obstacles to successful prevention and treatment efforts.

Consistent with the effort to target vulnerable groups, civil society actors indicate that the government supports differentiated prevention services for prison populations, commercial sex workers, men who have sex with men, youth, and women. However, according to one women’s CSA:

“...targeted prevention services reach 10% of those most at risk; the risk factor of multiple sex partners is problematic due to funding constraints such as USAID which prohibits interventions that reduce stigma of prostitutes and commercial sex workers; not only is this a barrier to the... detection of HIV/AIDS, it is a barrier for the detection of the more entrenched exploitation of trafficking in persons which breeds on this 'culture of silence'.”

Women and Girls

The National HIV/AIDS Policy calls for “more equal gender relations and empowerment of women” as a “vital” component of a successful prevention programme. In terms of prevention, the Policy stipulates “strengthening negotiation skills among women”. The only other specific prevention strategies focused on women are prevention of mother to child transmission, “optimal infant feeding options”, and universal VCT, access to ARV treatment and counselling for pregnant

women. Civil society actors reveal varying degrees of accommodation for women/girl specific prevention efforts depending on the particular focus of the agency. For those agencies that provide VCT, the degree of differentiated counselling varies from agency to agency depending on the training and previous experience of the agency and/or counsellor. Access to prevention education may be limited by local standards (e.g. prohibitions on condom education), and the age of consent law, despite a 2003 Cabinet approval for the provision of contraceptives to minors. As one women's organisation describes it:

“There is an effort to improve access to contraception for children; girls do not have non-discriminatory access to condoms. The issue of consent for the health work[er] is problematic in terms of balancing parental rights and the best interest of the child; age difference translate[s] into power differential in service provision to adolescents who are valued as non-sexual.”

Youth

Prevention interventions for youth are indicated in a variety of ways in the National Policy, though not necessarily by name. As a vulnerable group, they are targeted for education programmes, increased condom use and voluntary counselling and testing. They are also the target population for other strategies such as improving the ability of parents and guardians to engender positive attitudes and behaviours in children, providing HIV/AIDS information within a life skills context at educational institutions, and providing ARV prophylaxis for victims of carnal abuse. Quite a few service providers, both public and private, offer programmes specifically for young people and several facilities attempt to create a “youth-friendly” atmosphere, though this is hampered by policies that require parental consent before screening youth under the age of 16. Other barriers include “cultural norms, a lack of interested staff, judgmental attitudes and general malaise as indicated by civil society actors”, according to one CSA. The discussion in the previous section on access to condoms for girls also applies here for youth in general.

Men Who have Sex with Men (MSM)

Providing prevention services to the MSM community presents the Ministry of Health with a difficult challenge. Their own statistics estimate a seroprevalence of 25%, though independent research and anecdotal reports from CSAs suggest this figure may be quite low due to stigma associated with acknowledging same-gender sexual intimacy. Whatever the exact numbers, it is fair to say that this is the most vulnerable group in Jamaica and that strong homophobia makes it difficult to supply prevention services to them. As a result, only one NGO provides “safe space” for this group and only two conduct prevention interventions specifically addressing their needs. However, prevention counsellors island-wide routinely question clients about risk behaviours, which includes same-gender intimacy, and provide appropriate information if this behaviour is disclosed. Unfortunately, the lack of self-disclosure leaves many in this group with non-differentiated prevention messages. One of the primary reasons for this fear of disclosure, and the difficulty experienced by the MOH in funding projects aimed at the MSM population, is the

Offences Against the Person Act, which makes same-gender intimacy among men illegal. Though MOH leadership has regularly called for the repeal of this Act, and a couple of tentative comments in support of this repeal effort have come from elected officials, the public animosity towards any such move, led by religious and political leaders as well as some in the local intelligentsia, has made it all but impossible to accomplish.

Sex Workers (SW)

Sex workers share many of the same difficulties in receiving adequate prevention services as the MSM community, and in some cases, these two categories overlap creating a double stigma. Legal prohibitions and public shame (to a lesser degree) create a fear of disclosure and a high potential for exploitation (especially for adolescents). A few agencies, both public and private, offer programmes (education, condom distribution, and testing) for sex workers with outreach to the strip clubs, beaches and streets where sex workers solicit clients. Drug abuse prevention/treatment advocates have also identified the link between illicit drug use, sex work and a high incidence of sexually transmitted infections including HIV. As a result, they offer programmes targeting sex workers who are also using illegal drugs. Both public and private facilities encourage sex workers to drop in for counselling and testing. As with the MSM population, judgmental attitudes and a lack of interest on the part of some prevention workers pose the biggest social barriers to effective prevention efforts.

Intravenous Drug Users (IDU)

Intravenous drug use is not common in Jamaica and therefore is not seen to pose a significant threat to the spread of HIV. MOH statistics support this conclusion and result in a lack of any real prevention programmes targeting this group. It also leads many prevention/treatment providers to overlook this potential risk behaviour. Although intravenous drug use is a cultural taboo, the practice does exist in Jamaica and government health facilities deal with these drug users on a case-by-case basis. Legal prohibitions, including the possession of injecting equipment, create barriers for any kind of treatment or prevention efforts.

Migrants and Mobile Populations (including illegal immigrants)

Generally migrants and mobile populations have a very minor presence in Jamaica and therefore virtually no prevention or treatment efforts targeting them. However, increasingly there is recognition of the need to service this population given the recent increase in the incidence of deportation and the fluidity of the migrant population. A recent project relates to deportees who come in from USA and the UK who, with the support of the Ministry of National Security and a coalition of NGOS through recent initiatives, are being screen for, among other things, their vulnerability to HIV/AIDS and, where required, are being referred to relevant treatment or service locations. Another notable exception is the relatively recent phenomenon of refugees from Haiti arriving by boat on Jamaica's northern and eastern shores. It is believed that most of these refugees

are apprehended by authorities and deported back to Haiti. While awaiting deportation, they are given physicals, which include HIV testing, and provided necessary medical treatment.

Part III: Voluntary Counselling and Testing (DoC paragraph 19)

The National HIV/AIDS Policy stipulates expanded voluntary counselling and testing as a strategy (among many others) for achieving two of its four main objectives, Prevention and Treatment. As a result, MOH officials estimate that 356 public, NGO, FBO and public VCT sites are in operation (three of which are NGO or FBO sites), though only one NGO and sixteen public testing sites are listed on the current MOH public awareness brochures. The NAP website lists twenty government facilities where ARV treatment is available. Counselling is free at government and civil society facilities. Testing may be provided free, by donation, or for a payment of approximately US\$3. Counselling and testing is also available through private medical sites where typical doctor's fees and lab fees apply, approximately US\$35 and US\$20 respectively. The government and CS sites are located throughout the country though most are in the cities and larger towns. They may have training rooms with smaller counselling rooms or simply counselling rooms alone. The process for VCT usually involves registering for group education plus private counselling or private counselling alone. The actual blood sample is most often sent off-site for analysis, which may take 4 to 6 weeks, but rapid tests are becoming available in some areas with a lab test routinely provided for confirmation. In the former case, clients must make an appointment to receive the results of the test and receive post-test counselling. It is estimated that 56,000 samples of blood were tested between May of 2004 and August of 2005 and all of the donors should have had pre and post-test counselling. A positive result on an HIV test is notifiable to the Ministry of Health. These figures provide statistical tracking and help guide intervention strategies. Although the identities of HIV+ clients should remain confidential, in practice this is not always the case. Prevention education is included in both pre and post-test counselling. Though, according to a MOH official, it is not differentiated according to risk behaviours nor is any screening based on risk behaviours recommended. According to CSAs, the logic in this approach is that some people won't disclose their true behaviour due to the stigma attached and questioning an individual would only increase the potential for feelings of stigmatisation. However, several this policy is not followed by all CSAs, many of which claim to provide differentiated screening and prevention information. In all cases, different counselling is provided for HIV+ and HIV- test results and clients who receive a positive result are referred to ARV treatment sites. Another point of inconsistency lies in the area of required prevention tools. At VCT sites, the government claims that male condoms are required, however, a number of CSAs believe that no prevention tools are required. ARV treatment sites suffer the same lack of consensus, as there seems to be no consistent understanding on the part of the MOH officials or CSAs about the requirements for prevention tools.

Regarding prevention tools available in the private sector, male condoms are most commonly available, either free through CSA distribution efforts (both outreach and drop-in), through government sponsored vending machines at universities, the racetrack, and tourist sites for approximately fifty cents US, and through street vendors, pharmacies and retail sites where the cost runs from approximately US50 cents to US\$2 each. Female condoms are occasionally available free of cost at CSA sites or at pharmacies for roughly US\$1.50 to US\$4 each. The same

is true for water-based lubricants at a price of US\$1 to US\$5 per tube. Oral dams are available at a very limited number of pharmacies for approximately US\$1.50 each. All primary, secondary, and tertiary health sites are directed to offer opportunistic infection prophylaxis to HIV+ individuals. It has been reported, however, that the demand exceeds the availability of treatment in some case, though it is unclear as to how widespread this problem may be.

Part IV: Empowerment of Women (DoC paragraph 14, 59, 60, 61)

Over the years, the Government of Jamaica, in collaboration with CSAs, has made various efforts to protect and empower women. Although there is no specific body within the National Programme that addresses women's issues, the Bureau of Women's Affairs, an umbrella organisation for several CSAs involved in women's issues, worked closely with MOH officials in the development of the National Strategic Plan and National HIV/AIDS Policy. This was accomplished through women's forums and general planning meetings. Some of the strategies to empower women include increasing condom use including female condoms, strengthening condom negotiation skills, development of women-targeted advertising campaigns including a mini-drama to be aired on television, and focusing on women's issues during World AIDS Day. Additional efforts include providing VCT to all pregnant women, and training all healthcare workers in prevention of mother to child transmission (MTCT). The National ad campaigns and efforts to combine agencies (e.g. domestic violence, child protection, and job-training programs) are also seen as a means of assisting women to understand and articulate their health needs. Female condoms are available at the National Family Planning Board, some hospitals and clinics, a few pharmacies, a very limited number of sex toy stores, and sporadically through MOH or CSA distribution programmes. CSAs and the MOH also demonstrate condom usage (sometimes using anatomical models), and distribute brochures and posters about why and how to use female condoms. This information is also printed in the National HIV/AIDS Policy booklet. CSAs have assisted in implementing most of these strategies though "dissemination of written brochures, posters, referrals to quality agencies and wide-ranging introductions to available personnel and services". Despite all these efforts, the strategy of improving condom negotiation skills has had little success according to several CSAs.

There seems to be universal agreement among CSAs that women are being made aware of HIV/AIDS and the risks associated with unprotected sex. Most CSAs are familiar with specific educational programs (both government and civil sector) for women that focus on skills development, and prevention methods. They also believe that information related to women and HIV is widely available, though not all agree on its gender sensitivity or gender specificity. In addition, CSAs identified the following barriers faced by women in accessing HIV treatment: social and cultural practices (e.g. stigma attached to the infection), issues of forced sex, lack of negotiating skills, poverty and unemployment, gender imbalance "perpetuated in some instances by women", and in regard to HIV/AIDS treatment staff, a lack of interest, judgmental attitudes and "general malaise".

The Centre for the Investigation of Sexual Offences and Child Abuse focuses on providing medical attention for victims who are sexually abused (including HIV prophylactic treatment); though as one CSA put it,

"IF the police turn up when called, IF there is an investigation and IF the female is not killed in her attempt to prosecute, there are rape kits and HIV prevention polic[ies] available."

According to an umbrella agency for women's organisations, the Government has strengthened legal and policy frameworks within the context of the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) that promotes gender equality, women's empowerment and stigma reduction for those infected, affected or at risk of HIV/AIDS. While other CSAs agreed, many were unsure about this.

Recommendations for how the government can improve its efforts include more public education for all ages including life skills training, policy changes, increased employment, greater access to income generating opportunities, greater focus on the poor and rural women, more public education for men, screening of migrant workers, and dispelling common myths in relation to sexual practices (such as sleeping with a virgin to cure a sexually transmitted infection). Though the Government has attempted to address the issue of poverty and unemployment numerous times through a variety of initiatives, most of these efforts have lacked sustainability. The Government has sponsored some public education efforts and ad campaigns to encourage active participation by men in the effort to protect women from further infection, though their effectiveness has been questioned.

Part V: Protecting the Human Rights of PLWHAs and Vulnerable Groups (DoC paragraph 13, 18, 58, 96)

The Government of Jamaica receives regular criticism from a wide range of source for its poor record on human rights. In the context of HIV, The National HIV/STI Control Programme has addressed this issue in both the National Strategic Plan and the National HIV/AIDS Policy. This is especially important considering the high prevalence rate within vulnerable groups including 10% among female sex worker in Kingston, 20% among female sex workers in Montego Bay, 12% among prisoners, and 25% among homosexual/bisexual males (a figure that many believe is much higher). The National Policy, in its call for the “promotion and protection of human rights”, includes the following objective:

To affirm the rights of persons living with or affected by HIV/AIDS and the rights of those most vulnerable to HIV/AIDS through an environment that:

- **reduces HIV/AIDS related stigma and discrimination**
- **improves access to condoms, prevention information and skills, ARV and other treatment for opportunistic infections (OI), infant formula, VCT and family and community support**

Significant inroads have been made in providing the access stated. Educational outreach efforts conducted or supported by the MOH target some vulnerable groups (PLWHA, MSM, prisoners and SWs), ARV therapy is increasingly available (though the fee system remains problematic for some), prevention of mother to child transmission is being improved, and VCT access is expanding. However, CSAs, international development partners, and MOH personnel generally agree that stigma and discrimination still remain significant problems. At the current time, no national legal framework specifically protects the rights of PLWHA or marginalized groups from discrimination. An anti-discrimination act for PLWHA is in the drafting phase, with hope that it can be passed by parliament in three years. No such legal framework has been undertaken for other vulnerable groups. The MOH has begun a national educational and advertising campaign aimed at changing people’s attitudes toward PLWHA to reduce discriminatory practices. Posters, brochures, television and radio messages promote this behaviour change. Most civil society actors who work in this arena also promote non-discrimination (against PLWHA) through a variety of education projects targeting youth and adults including a school curriculum, publications, presentations and public dialogue. For men who have sex with men, only three NGOs routinely implement antidiscrimination programmes focusing on this group. Other marginalised groups appear to have no specific advocates. While the government claims to support non-discrimination messages for all vulnerable groups, it seems their programming and funding support is directed toward PLWHAs exclusively.

Since neither the Charter of Rights and Freedoms nor any legislation specifically protect any vulnerable groups, members of vulnerable groups must respond to incidents of discrimination based on the general rights and laws afforded to any citizen and following the avenues of justice available to the public – i.e. they can seek recourse from the Public Defender, the Office of the Ombudsman, or the Department of Public Prosecution. As a result of the general nature of these

protections, there has yet to be any public record to indicate that these avenues have been pursued by any members of a vulnerable group. While this may be due to confidentiality issues, in many cases it is simply a matter of the laws not providing the protections needed. For example, employers can still fire people for their HIV status or sexual orientation. Property owners can evict tenants for the same reasons. In cases where the laws may provide some recourse, members of vulnerable groups often do not understand their rights or fear the consequences of taking legal action (e.g. the exposure of a public court case or the costs involved). For many, the most support they can hope for is a sympathetic ear. As one CSA put it,

“...usually the story is just listened to, the child however remains out of school, the employee becomes unemployable, the child remains raped without counselling.”

In some cases, the victim's experience of abuse is documented. Two NGOs (one with the assistance of the MOH) maintain a register of human rights abuses for PLWHA. Another NGO monitors violations against MSM. However, these records have been accessed primarily by foreign actors (lawyers involved in asylum cases and human rights reporters), not by Jamaican officials.

SECTION 5 MONITORING AND EVALUATION

The issue of monitoring and evaluation (M&E) has received considerable attention from the National HIV/STI Control Programme, especially in the past 2 years. During this time, the capacity of the M&E Unit has been greatly enhanced. It currently tracks 104 global and/or national indicators that are linked to target outcomes including:

- 1) HIV/AIDS/STI Impact
- 2) Behaviour Change Communication: Knowledge, Attitudes and Behavioural Outcomes
- 3) Voluntary Counselling and Testing Services
- 4) Orphans and Vulnerable Children
- 5) Prevention of Mother To Child Transmission
- 6) Condom Marketing and Distribution
- 7) Policy, Advocacy and Human Rights
- 8) Blood Safety
- 9) Treatment, Care and Support
- 10) Post Exposure Prophylaxis
- 11) Stigma and Discrimination
- 12) Monitoring and Evaluation Strengthening
- 13) Multi-sectorial Response
- 14) National Commitment

Reports are generated by the M&E Unit on an annual, biannual or quarterly basis. Various entities contribute data for these reports including the Surveillance Unit (which collects data on prevalence rates and similar statistics), the PMTCT Coordinator, the Ministry of Education, the National Family Planning Board, the Behaviour Change Communication Coordinator, the National AIDS Committee, the STI Coordinator, the Treatment Coordinator, UNICEF, the Global Fund Coordinator, the Ministry of Labour, the Policy Coordinator, the National Public Health Lab, the VCT Programme Manager, the Capacity Building Unit, civil society advocacy groups (including PLWHA advocates), and the Finance Unit. The criteria correspond with components of the National Strategic Plan, UNGASS Commitments, the Global Fund grant, the World Bank loan commitments, and USAID commitments. The primary audience for these reports includes MOH and other government officials, funders, the National AIDS Committee, and the Country Coordinating Mechanism partners. Of these reports, the only one readily available to the public (via the website or by request) is the quarterly update for the Global Fund. While this report provides valuable information, it is specific to the Global Fund targets and does not cover all aspects of the National Strategic Plan. In addition, the budget information applies only to the eight Global Fund objectives. This budget document is broken down by allocation to the general objectives, disbursements to sub-recipients and administrative expenses.

SECTION 6 RECOMMENDATIONS

Based on reports from Government representatives, international development partners, civil society actors, private sector leaders, and people infected or affected by HIV/AIDS, this inquiry has identified the following recommendations:

For the Government of Jamaica:

- Address problems of stigma and discrimination more aggressively, in particular, fast-track efforts to pass national anti-discrimination legislation. This has been the most commonly identified deterrent (by CSAs, international development partners, and Government officials) to successful prevention and treatment efforts.
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- Address the institutional framework within which Prevention and Treatment services are offered to make them more user-friendly, as well as redesign the legal framework to support prevention and care initiatives.
- Rigorously address issues of poverty, corruption and crime especially as it affects women, children and vulnerable groups.
- Cultivate a culture of accountability and transparency among all public servants.
- For all key Ministries, strengthen the response to HIV/AIDS including the appointment of an HIV/AIDS coordinator for each Ministry to facilitate the implementation of HIV/AIDS Workplans, and to provide representation at all NAC meetings.
- Identify and pursue sustainable funding mechanisms.
- Address issues of confidentiality.
- Increase funding support for non-ARV treatments and other medical bills.
- Develop and widely disseminate nutritional guidelines and recommendations for complementary healing modalities.
- Promote “meaningful co-ordination” of efforts between Government entities, international development partners, civil society, and the private sector.
- Continue to strengthen the monitoring and evaluation abilities of all Ministries especially as it relates to identifying verifiably effective prevention efforts.
- Increased access to palliative care.
- Increase access to psychosocial support for PLWHA and their partners.

- Sensitize all members of the Constabulary Force about the issues facing vulnerable groups and assign a senior officer to monitor claims of discrimination and/or abuse of vulnerable groups.
- Continue to enhance the independence and stature of the National AIDS Committee.
- Improved lab testing.
- Facilitate easier access to funding for CSAs including de-bureaucratizing the procurement framework which currently constrain CSAs effective use of funding resources
- Improve financial monitoring sub recipients, i.e. administrative versus direct services. A very common complaint is that an excessive amount of money is spent on training sessions, often at expensive resorts. It has also been reported that the same individuals are recruited for training.
- Improve public access to budget, monitoring and evaluation, and policy reports.

For Civil Society Actors:

- Better mechanisms to communicate with CSAs, especially those who are unable to participate in NAC activities.
- Improve advocacy skills for effective implementation of national policies and legal frameworks at both the local and national level.
- Promote “meaningful co-ordination” of efforts between Government entities, international development partners, civil society, and the private sector.
- Strengthen the implementation, monitoring and evaluation capacity of all CSAs especially as it relates to identifying verifiably effective prevention efforts.
- Increase participation in and support of the National AIDS Committee.
- Encourage religious leaders to take a firm stand opposing discrimination directed toward all vulnerable groups.
- Increase fiscal accountability and transparency of NGOs, CBOs, and FBOs.

For the Private Sector:

- Expand efforts to educate the private sector about HIV/AIDS and adopt workplace policies.
- Encourage all businesses to adopt strict anti-discrimination policies with clear penalties for those who engage in discriminatory practices.
- Promote “meaningful co-ordination” of efforts between Government entities, international development partners, civil society, and the private sector.

For the International Community:

- Promote “meaningful co-ordination” of efforts between Government entities, international development partners, civil society, and the private sector.
- Assist in strengthen the monitoring and evaluation capacity of all Government agencies and CSAs especially as it relates to identifying verifiably effective prevention efforts.
- Include all vulnerable groups when providing assistance to targeted prevention/treatment programmes.
- Facilitate easier access to funding for CSAs.
- Expand programming to support efforts at the Parish and community level.