NATIONAL HIV • STI • TB UNIT

ANNUAL REPORT 2016

Ministry of Health

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This document presents the HIV/STI/Tb Unit report covering the period of January – December 2016. It reflects implementation of the National Integrated Strategic Plan 2014 – 2019 through the outstanding coordination of the National HIV/STI/TB Unit in collaboration with the National Family Planning Board, other government agencies, civil society organisations and the private sector.

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ACKNOWLEDGEMENT

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Special thank you to the tireless health care practitioners, HIV project managers, HIV advocates and persons living with HIV for their dedication and concerted efforts in the continuous prevention, management, treatment, care and support for those infected and affected by HIV and AIDS.

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Disclaimer

Unless otherwise stated, the appearance of individuals or groups in this publication gives no indication of HIV status, sexual orientation or gender identity.

LIST OF ACRONYMS

AC	Adherence Counsellors
ACCPAC	Accounts Package (SAGE)
AIDS	Acquired immune deficiency syndrome
ANC	Antenatal Care
APWG	Adolescent Policy Working Group
ART	Antiretroviral Treatment
ARV	Antiretroviral
BCC	Behaviour Change Communication
BoJ	Bank of Jamaica
CaReQIC	Caribbean Regional Quality Improvement Collaborative
CBOs	Community based organizations
CCM	Country Coordinating Mechanism
CD4	cluster of differentiation
CDC	Center of Disease Control and Prevention
CF	Community Facilitators
CIs	Contact Investigators
CM	Case Managers
CSO	Civil Service Organization
CSS	Community System Strengthening
CXC	Caribbean Examination Council
DNA	Deoxyribonucleic Acid
EEHRTWG	Enabling Environment and Human Rights Technical Working Group
eMTCT	Elimination mother –to-child transmission
ERP	Economic Reform Programme
FAACC	Fort Augusta Adult Correctional Centre
FACS	Fluorescence-activated cell sorting
FSW	Female Sex Worker
GDS	Genital Discharge Syndrome
GF	Global Fund
GIPA	Greater Involvement of Persons Living with HIV and AIDS

GOJ	Government of Jamaica
HARC	Horizon Adult Remand Centre
HBI	Home-based Interventions
HFLE	Health and Family Life Education
HLM	High-Level Meeting on HIV and AIDS
HSTU	HIV/STI/Tb Unit
HTC	HIV Testing and Counselling
INPRI	International Procurement Institute
JCCM	Jamaica Country Coordinating Mechanism
KAPB	Knowledge, Attitude, Practices and Behaviour
KP	Key populations
KSA	Kingston and St. Andrew
LFA	Local Funding Agent
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and Intersex.
LTFU	Loss To Follow-up
M&E	Monitoring and Evaluation
MER	Monitoring, Evaluation and Research
MoF&P	Ministry of Finance and Public Service
MOH	Ministry of Health
MSM	Men sex with Men
NASA	National AIDS Spending Assessment
NERHA	North Eastern Regional Health Authority
NFM	New Funding Model
NFM	New Funding Mechanism
NFPB	National Family Planning Board
NGOs	Non-government organizations
NISP	National Integrated Strategic Plan
NPHL	National Public Laboratory
OIG	Office of the Inspector General
OPD	Office of the Public Defender
PCR	Polymer Chain Reaction
PCU	Project Coordinating Unit

PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PHDP	Positive Health Dignity and Prevention
PITC	Provider Initiated Counselling and Testing strategies
PLHIV	People Living with HIV/AIDS
PMTCT	Preventing mother-to-child Transmission
PR	Principal Recipient
PSIS	Prevention Services Information System
RHA	Regional Health Authority
RTC	Retention in Care
S&D	Stigma and discrimination
SDGs	Sustainable Development Goals
SERHA	South East Regional Health Authority (
SHA	Sexual Health Agency
ST. CACC	St. Catherine Adult Correctional Centre
STI	Sexually Transmitted Infection
SW	Sex workers
TB	Tuberculosis
TCS	Treatment, Care and Support
TFACC	Tamarind Farm Adult Correctional Centre (
TFM	Transitional Funding Module
TG	Transgender
TRP	Technical Review Panel
TSACC	Tower Street Adult Correctional Centre (
TSIS	Treatment Services Information System
UIC	Unique Identifier Code
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VBI	Venue-based Intervention (
VCT	Voluntary counselling and testing
WHO	World Health Organization
YATWG	Youth and Adolescent Technical Working Group

MESSAGE

Dr. Christopher Tufton
Minister Of Health

Jamaica remains committed to ending the AIDS epidemic by 2030. The country hopes to do this by building on gains made over the past three decades and tackling existing challenges to halting and reversing the spread of this manageable disease.

The Ministry of Health continued making strides towards this ambitious goal through work on various areas namely: prevention, care, treatment and support, a focus on vulnerable groups and the continued strengthening of an enabling environment for effective responses to the threat posed by HIV.

Key achievements in 2016 include the drafting of the country's second HIV/AIDS Policy, which will strengthen Jamaica's policy and legal framework for sexual and reproductive health and HIV prevention, treatment and care services.

Also, in 2016, Jamaica began a new performance period based on the Global Fund Grant Agreement with 19 implementing stakeholders. The Jamaica PEPFAR/USAID Grant, which began in 2015 and continued in 2016, had 12 sub-recipients, 10 of whom were also supported by the Global Fund.

Currently, 85% of the approximately 29,000 persons living with HIV infection in Jamaica have been diagnosed. Figures indicate that 75% of patients diagnosed have been linked to care and of those linked, 67% have been retained in care.

Mother to child transmission of HIV continues to decline, with 1% of babies being infected with HIV in 2016 from 2% in 2014. However, Jamaica has not been able to achieve the targets required to secure elimination status because of a lag in the achievement of the targets set for the key monitoring indicators. These gaps must be identified and addressed across the health regions.

The national programme made tremendous progress in reaching and testing key populations of female sex workers and men who have sex with men. In 2016, more than 4,000 MSM were reached and 1602 were tested while over 8,000 female sex workers were reached. A total of 1,675 inmates across five adult institutions were reached with prevention activities. Of this number, 1,598 were tested for HIV and 1,575 for syphilis.

In addition, care and support teams were further enhanced during the year with the addition of a psychosocial support coordinator and case managers to the cadre of psychologists, social workers and adherence counsellors working to meet the psychosocial needs of persons living with HIV.

Despite these gains, the country still faces significant challenges in addressing HIV. In the period under review, there were delays in implementing grant funds because of issues

related to administration and capacity. There were also gaps in the continuum of care, which included challenges with linkage and retention in care. a shortfall in ARV coverage and viral suppression, and persisting stigma and discrimination.

Jamaica continues to move forward towards the UNAIDS goal of ending AIDS by 2030 and much remains to be done. Improved collaboration and clearly documented guidelines on procedures and timelines are needed to help regional health authorities and implementing partners improve grant implementation. Home-based and peer link strategies which have proven effective in engaging key populations must be improved and scaled up. The Ministry will be seeking the help of external partners to improve supply chain management to reduce incidents of stock-outs of antiretroviral therapy. There are also plans to increase the number of treatment sites in 2017.

Capacity building, coordination, collaboration, stronger partnerships, and even greater focus on ensuring the needs of the underserved are met, are some of the critical areas that we must work towards in order to achieve the global goal of ending AIDS in the next fourteen years.

MESSAGE

Sancia Templer

Permanent Secretary

The Government of Jamaica (GOJ), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) and the United States Agency for International Development (USAID) remain the three major funders of the national HIV/AIDS response in Jamaica, which is coordinated by HIV/STI/TB Unit.

The importance of an enabling policy, legislative and human rights framework to the HIV/AIDS response has been recognised and a number of activities in the national response in 2016 reflected this, including the development of the HIV/AIDS Policy. The revised policy was developed through a consultative approach among stakeholders across all parishes and the policy statements were validated as they related to the prevention of HIV infections; treatment, care and support; enabling environment & human rights; mitigating the impacts of HIV; and strengthening community systems for responding to HIV.

Steps were taken to improve the financial management systems for the Global Fund and USAID/ PEPFAR grants in 2016, including implementing a new financial reporting template and monthly disbursements of funds to implementing entities; organising grant management training; work plan review meetings and conducting site visits with stakeholders to boost implementation strategies.

Measures were adopted to strengthen care, treatment and support for the estimated 29,000 individuals living with HIV in Jamaica.

In order to build capacity, various levels of training were provided to all categories of staff. The Treatment Readiness/Treatment Literacy training was conducted with over 150 persons across nine staff categories. Work continued in 2016 to realise The Greater Involvement of Persons Living with HIV and AIDS (GIPA) in the national response. Multiple-Day capacity building workshops were also conducted with GIPA to help adherence counsellors and PWHIV community leaders' use of the Positive Health Dignity and Prevention (PHDP) Curriculum. Trained Community Facilitators (CF) has been deployed into Ministries, Departments and Agencies with the support of the National Family Planning Board.

Additionally, the psychosocial support teams were strengthened with the appointment of a national psychosocial support coordinator and case managers.

During 2016, the prevention efforts focused strategically on three groups: men who have sex with men (MSM), sex workers (SW) and transgender (TG). While key populations were the focus of most prevention activities during the year, work was also done to build knowledge and provide HIV and syphilis testing with other vulnerable populations (inmates and adolescents) and the general population.

The achievements and lessons learnt from 2016 have underscored that while there has been progress, much remains to be done. Achieving the end of AIDS requires the input of all stakeholders at the national level and the support of our international partners. Under the guidance of the national strategic plan, the Ministry of Health looks forward to continuing progress made in 2016 and addressing gaps which persist in the capacity of all implementing partners, retention of patients in care, stigma and discrimination and monitoring and data collection.

MESSAGE

Dr. Nicola Skyers

Senior Medical Officer,HIV/STI/TB Unit

In 2016, the partners in the HIV response continued the work towards control of Jamaica's HIV Epidemic.

The statistics show that in 2016, 85% of the estimated number of PLHIV were aware of their status, 43% of those diagnosed were on treatment and 55% of those on treatment were virally suppressed. Provider Initiated Counselling and Testing (PITC) strategies (STI Clinic attendees, adult hospital admissions, among others) continue to be the most efficient avenue for diagnosing PLHIV, with most PLHIV being diagnosed from these PITC access points.

The upward trend in ART access continued in 2016 and psychosocial support efforts contributed to the increase in the number and proportion of PLHIV who are virally suppressed. Access to viral load testing improved markedly in 2016, with 90% of PLHIV on ART having a viral load result documented in their health record.

These strides made reflect the strengthening of partnerships for delivery of prevention, treatment, care and support to PLHIV in Jamaica and the Ministry of Health thanks all stakeholders in the response.

Despite this progress however, deeply entrenched issues around stigma (both internal and external) and discrimination continue to pose a serious threat to the control of the HIV epidemic. Shifts in societal norms and attitudes are painstakingly slow in coming. Thus, efforts to mitigate the impact of stigma and discrimination (in particular within the health care setting) have been and must continue to be on-going and must involve the efforts of a wide range of partners.

ARV stock management was another challenge in 2016. There was a major stock out in the third quarter of the year and delays in the procurement process continue to stymie our efforts to address this gap. Limitations within the health care system continue to hamper expansion of the ART Programme. The limitations in physical space and the consequent inability to increase staffing negatively affect efforts to increase access to ART for PLHIV. Staffing challenges at the MOH level have also limited advancement of the management of the Unit's programmes, in particular, those addressing Tuberculosis and other STIs.

We view 2017 as a year which presents many opportunities:

- In 2017, the roll out of the WHO guidelines for ART initiation "test and start" will begin in Jamaica and we will build on the yeoman efforts, which began in 2016, to prepare for these systems.
- Technical assistance to improve ARV supply chain management will be accessed and

data systems to increase ARV monitoring at the dispensing sites will be explored and engaged as necessary. The use of the Global Fund's WAMBO platform should address some of the gaps in the process.

- A media campaign aimed at reducing loss to follow up (LTFU) and improving adherence will complement the roll out of the new ART guidelines. Peer support strategies will be explored and scaled up as best practices are identified.
- Significant work will be done to further improve our surveillance and treatment data systems with the linkage of stand-alone databases at the national and sub-national levels.

As Jamaica's HIV epidemic evolves, HIV/STI/Tb Unit remains committed to strengthening our systems and collaborating with partners to provide quality services to those at risk of, infected with, and affected by, HIV.

As Jamaica's HIV epidemic evolves, the mandate and commitment of the HIV/STI/Tb Unit remains steadfast as that of supporting the provision of quality services to those at risk of, infected with, and affected by HIV.

MESSAGE

Dr. Denise Chevannes

Executive Director, National Family Planning Board

The year 2016 was a year of great progress in Jamaica's national HIV/STI/TB response. Jamaica has come a far way in the fight against HIV and AIDS and we continue to make strides towards the achievement of the Sustainable Development Goals (SDGs) and the United Nation's 90-90-90 goals.

Out of an estimated 29,000 persons living with HIV in Jamaica, approximately 85% are now aware of their status, making Jamaica only 5% away from achieving the first 90-90-90 goal: 90% of persons living with HIV knowing their status. Of those who are aware of their positive status, 75% have been linked to care and 67% of those linked are retained in care.

In 2016, the National Family Planning Board (NFPB) was able to significantly increase our figures for our Reach and Test initiative, specifically for our main target groups: men who have sex with men (MSM), female sex workers (FSW) and transgenders (TG). The reach and test figures for the MSM population went from 324 in 2015 to 578 in 2016; and 94 in 2015 to 327 in 2016 respectively. In 2015, 635 FSWs were reached and 132 tested; these figures increased to 1,066 and 585 respectively. The transgender community was a new target population for 2016 and our reach and test initiatives are still in its initial phase of trial and error and lessons learned. This population proved to be the most difficult to reach and seems to be a small fraction of the population. With these challenges, the NFPB was still able to reach 16 TGs and test 7 as at December 2016.

Although special attention was paid to these populations, much of the NFPB's work was conducted among the general population through integration of services, including voluntary counselling and testing (VCT); sexual and reproductive health (SRH) information and education; contraceptive distribution and counselling; and stigma, discrimination and human rights education.

Collaboration with the Government of Jamaica, the Ministry of Health and its related agencies, civil society organisations, faith-based and community organisations, has proved to be essential if we are to achieve the goal of ending AIDS by 2030. The achievements in 2016 demonstrate that it is in fact an achievable goal, however there is still much to be done. The NFPB looks forward to continuing in this charge to eliminate AIDS and to ensure that all Jamaicans achieve optimal sexual and reproductive health services throughout their lifetime.

FOREWORD

The Government of Jamaica (GoJ) is now the leading financial contributor to ending the AIDS epidemic in Jamaica.

Historically, the HIV response in Jamaica has been largely funded by international donors and governments. However, since 2015, the GoJ began increasing the budgetary allocations to fill the gaps in funding as key donors reduced their allocations.

Contributions by the GoJ now stand at 38%. The total Government of Jamaica contributions through the recurrent budget and through its contribution towards the USAID & Global Fund grant funded projects, was J$646.54M in 2016. The GoJ's contributions represented an increase of approximately 83% when compared with the amount committed in 2015 (J$353.59M). The Global Fund was the second largest contributor to the national response accounting for 37% (J$629.47M) of budgetary allocation and a 44% increase in contributions when compared with 2015.

Although challenging, the shift in funding paradigm towards local funding means that Government is acknowledging ownership of the epidemic and will have to ensure mechanisms are in place to foster accountability in the implementation of the national HIV response.

Another notable milestone in 2016 was the significant achievement by the country in diagnosing persons living with HIV. Four out of every five persons living with HIV in Jamaica (88%) know their status. This is the highest percentage in the English-speaking Caribbean and close to the 90 per cent target. The magnitude of this achievement is such that up to 2010, epidemiological data indicated that only half (50%) of those infected with HIV were aware of their status. Six years later, the figure moved to 81% of persons diagnosed and aware of their status.

This success is attributable to the range of testing options, including community outreach approaches, provider-initiated testing, and focused services for key populations.

Further, the progress that Jamaica through the National HIV/STI/TB Unit and the National Family Planning Board – Sexual Health Authority continues to make is made possible through the continuous support, commitment and dedication from all key partners in the response to HIV and AIDS and SRH.

The HIV response in Jamaica is led by four technical components: Prevention and SRH; Treatment, Care and Support (TCS), Enabling Environment and Human Rights and Monitoring and Evaluation (M&E). In 2016, some notable initiatives were undertaken to improve the HIV response.

The HSTU significantly expanded its outreach efforts and programming for the adolescent population through its All-In initiative. A "Teen Hub" was opened at the Half Way Tree Transport Centre in Kingston. The hub serves to increases access to basic HIV and SRH services for those 16 years and older such as testing (HIV and Syphilis), referral for STI screening, condoms, HIV risk reduction counselling, information on HIV prevention. Young persons are also able to access other services relating to mental health, homework assistance, career guidance and access to computers and internet.

A treatment cascade for key populations is now available for the first time in Jamaica for use

by the HSTU. The generation of this data, if adequately used, has the potential to strengthen the country's approach to treat, care for and support PLHIV.

Despite the achievements over the year, significant gaps remain with respect to treatment. Jamaica will need to double efforts to ensure that, once diagnosed, people are linked to treatment, retained in care and achieve viral suppression. Data shows that just one in three (35%) persons estimated to be living with HIV was accessing treatment in 2016. Approximately 21% of the estimated people living with HIV were virally suppressed.

Of concern is that in 2016, surveillance data estimate that there are 30,000 persons living with HIV in Jamaica up from 27,000 in 2015. In 2016, there were significant increases in the total number of HIV, advanced HIV cases, AIDS and deaths reported. HIV cases increased by 41.7%, advanced HIV by 30%, AIDs by 47.1% and AIDS-related deaths by 20.1%. Further, of the total number of newly diagnosed cases in 2016, some 15% were reported notified for the first time as deaths.

This 2016 report contains information on the HIV response between January 1 and December 31, 2016. It includes overviews of programmatic activities geared at reducing new infections, HIV-related stigma and discrimination, actions at policy and legislative reform, and summaries of findings from analyses of programme data.

EXECUTIVE SUMMARY

OVERVIEW

At the end of 2016, an estimated 30,000 persons were estimated to be living with HIV in Jamaica at a prevalence rate of 1.7%. Since 1982, 35,904 persons were diagnosed with HIV, the majority of whom (72.6%) are still alive. Jamaica continues to exhibit features of both a generalized and concentrated HIV epidemic. The prevalence in the general population is estimated at 1.7%, however surveys show higher HIV prevalence in at-risk groups. Key populations that constitute the concentrated epidemic include female sex workers, men who have sex with men, transgender persons, homeless persons, and inmates. National surveys indicate that one out of every three (38.9%) men who have sex with men (MSM) is HIV-infected, 2.9% of female sex workers is HIV-infected, 3.3% of inmates are HIV positive and 4% of homeless drug users.

In 2016, 2,015 newly diagnosed cases were reported to the MoH. Of this, 15% or 305 were reported to the National Epidemiology Unit for the first time as deaths. This is an indication that despite immense success in testing in 2016 which indicates diagnosis levels at 88%, there is still need for wider testing.

Persons aged 30-39 years accounted for the largest proportion (25%) of newly diagnosed cases in 2016 followed by those aged 20 – 29 years old accounting for 23% of the total reported cases. The cumulative male to female ratio for persons reported with AIDS in 2016 was 1.32:1. However, although the epidemic affects more men than women, over time females are accounting for an increased proportion of the AIDS cases that are reported annually. There is variation in the gender distribution of reported AIDS cases across the lifespan. Young females account for the larger share of reported cases in the 10 – 29 age range.

Three quarters (75%) of Jamaicans living with HIV are aged 20 to 49 years old. More than half (65%) of Jamaicans living with HIV currently reside in the most urbanized parishes (Kingston and St. Andrew, St. Catherine, and St. James).

STRATEGIC INVESTMENTS IN THE FIGHT AGAINST HIV/AIDS

Jamaica's approach to tackling the HIV epidemic is a multi-sectoral effort that engages persons living with HIV and stakeholders from the Government, non-governmental organizations, civil society, private sector groups, and international development partners. Jamaica is experienced in planning for the strategic implementation of a national response. Since 1988, Jamaica has had a national plan to guide the response to HIV and a well-established

national programme.

The three sources of funding for the national programme 2016 were The Government of Jamaica, The Global Fund to fight AIDS, Tuberculosis and Malaria (GF) and United States Agency for International Development (USAID).

The Government of Jamaica's cash allocation of J$646.54M made it the largest funder of the national response; the 2016 contribution represents an increase of approximately 45% when compared with the amount committed in 2015 (J$353.59M). The Government of Jamaica also provided in kind contributions, as it had done in previous years.

STRENGTHENING THE APPROACH TO FIGHTING HIV/AIDS

The HSTU embarked on efforts to strengthen data and information management capacities.

A national key population treatment cascade was developed for the first time. While the HSTU has experience in generating treatment cascades for PLHIV, a treatment cascade for population groups had never been prepared. The Biostatistician from the M&E Unit at the MOH benefited from regional training hosted by CDC. The exposure to the training allowed for the Unit to generate the national key population treatment cascade for 2016.

The HSTU introduced, DHISII, a new web-based data collection platform that links the databases across all treatment sites. Prior to the introduction of the database, it was difficult to, among other things, track and manage patients who sought care at multiple sites and collate data for national analysis and reporting. Therefore, the HSTU anticipates that the introduction of the platform will reduce the number clients who are lost to follow up. Secondly, in 2016, the HSTU implemented the Unique Identifier Code (UIC) for PLHIVs. Together, the implementation of both systems will enable both the HIV treatment sites and prevention services to be able to access a comprehensive history of services received by each client.

The HSTU has expanded its outreach efforts and programming for the adolescent population.

The Adolescent and Youth Component of the National HIV/STI/Tb Unit was introduced as new component to the National Response. The national response for this adolescents gained greater force starting in 2015, with the introduction of the All In initiative, a partnership between the Ministry of Health and UNICEF. The All In initiative targets adolescents aged 10 to 19 years and is part of the global push to end the AIDS epidemic for all by 2030. The findings from the implementation of All In in the Jamaican context, were used to leverage further support for the introduction of HIV prevention treatment and care programming for

this age group. The mandate of the Adolescent and Youth component is guided by the All In Youth and Adolescent Technical Working Group (YATWG) and the Adolescent Policy Working Group (APWG).

The "Teen Hub", was implemented at the Half Way Tree Transport Centre in Kingston. The hub serves to increases access to basic HIV and SRH services for those 16 years and older such as testing (HIV and Syphilis), referral for STI screening, condoms, HIV risk reduction counselling, information on HIV prevention. The young persons are also able to access other services relating to mental health, homework assistance, career guidance and access to computers and internet.

The HSTU has introduced new approaches to reaching key populations.

In 2016, the National Programme introduced Home-based Interventions (HBIs), also known as "lymes" or "hang-outs" to better target and serve the MSM population. This approach is a revision of the workshop session strategy that was previously used to reach the MSM population. The HSTU uses the HBIs to provide services in spaces that MSM would deem to be private, safe and comfortable, and to build trust and expand networks through snow-balling and social media integration. The "lymes" incorporate social activities such as games and they have attracted a wider cross-section of MSM/TG.

KEY ACHIEVEMENTS IN THE FIGHT AGAINST HIV/AIDS

Closing the Gaps in the Continuum of Care: The treatment cascade for key populations is now available for the first time in Jamaica for use by the HSTU. The generation of this data, adequate used, has the potential to strengthen the HSTU's approach to treat, care for and support PLHIV. The 2016 cascade shows, for example, the nuances across key population groups. A greater number of homosexuals are linked to care when compared to bisexual men and female sex workers. However, greater numbers of bisexual men are retained in care. In terms of the number of PLHIV on ART and the prevalence of viral load testing and viral suppression, the homosexual population outpaces bisexual men and female sex workers.

The 2016 cascade shows for example, the nuances within the adolescent group along the continuum of care. While at least twice as any persons aged 10 to 14 years are linked to care when compared with those 15 to 19 years of age, far fewer 10 to 14 year olds are retained in care when compared with their older peers (15 to 24 years old). Consequently, the rates of viral load testing and viral suppression for 10 to 14 year old lag behind those of their peers.

Over the years, and this reporting period was no different delays in procurement have impacted the HSTU's capacity to manage its ARV stock. The HSTU anticipates that the introduction of E-Procurement System the Government of Jamaica's first electronic procurement platform and its establishment of the five (5) new Specialist Sector Committees to facilitate the timely processing of submissions for awarding contracts will significantly improve its ability to carry out its procurement functions.

Those efforts along with the implementation of the Unique Identifier Code (UIC) for PLHIVs and the implementation of the Caribbean Regional Quality Improvement Collaborative (CaReQIC 2.0) can greatly impact the lives of PLHIV in Jamaica.

CONCLUSION

The funding to the HSTU is the highest in it has been in the last six years, with J$1.68B allocated in 2016, compared with the 2011 budget allocation of approximately J$M 1.2. Of the three funding sources, The Government of Jamaica, The Global Fund to fight AIDS, Tuberculosis and Malaria (GF) and United States Agency for International Development (USAID), the government accounted for 38%. For every dollar that the Government if Jamaica committed in cash to the response in 2015, it contributed an additional 45 cents in 2016.

The HSTU was able to, in 2016, build on the foundation that it had established in previous years. During the reporting period, the HSTU expanded its programming by using information gathered from past experiences; strengthened its ability to use data to drive strategic and programming decisions and continued its efforts to engage with stakeholders to ensure that the national response remains relevant.

One of the key interventions introduced in was the Adolescent and Youth Component of the National HIV/STI/Tb Unit which was borne out of the experience with implementing the All In initiative.

The work of the HSTU continues in the face of challenges they face in reaching key populations. The HSTU has identified for example that it would necessary to prepare an engagement strategy for group of transgender persons.

CHAPTER 1: EPIDEMIOLOGY OF HIV

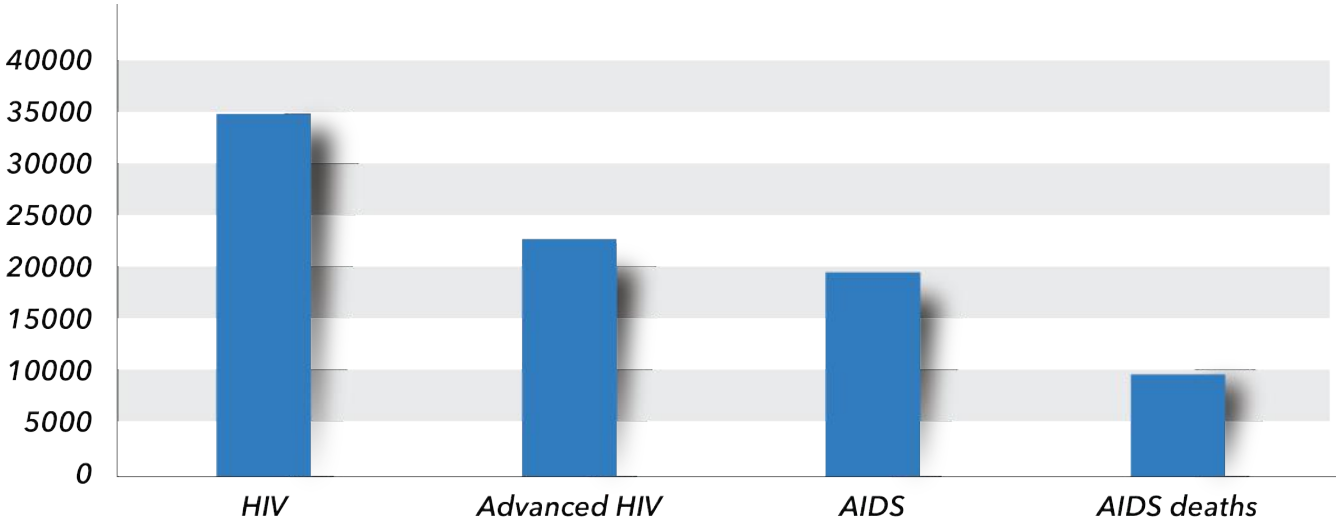
INCIDENCE AND PREVALENCE OF HIV IN JAMAICA

The Ministry's 2016 HIV Epidemiological Profile indicates that an estimated 30,000 persons in Jamaica are currently living with HIV, but approximately 12% are unaware of their status. Between January 1982 and December 2016, 35,904 cases of HIV were reported to the Ministry of Health. Of these, 9,821 (27.4%) are known to be deceased.

In 2016, there were 2,015 newly diagnosed cases, a slight decline from the 1,176 cases reported in 2015. In 2016,

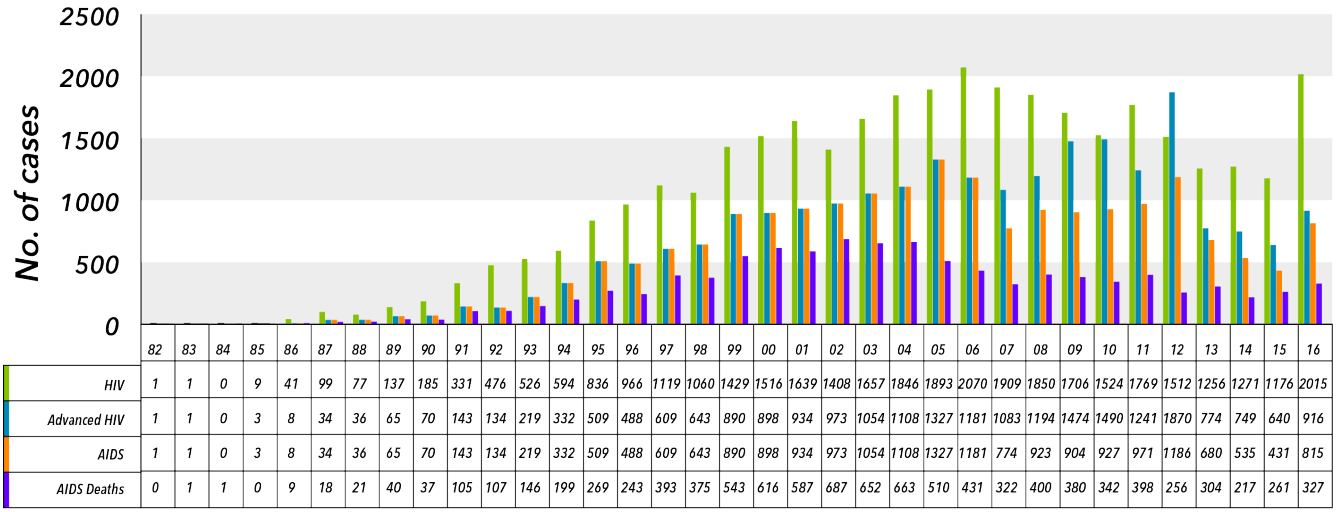
916 (522 males and 394 females) persons were reported to have advanced HIV compared with 686 in 2014. The Ministry of Health began monitoring cases of advanced HIV in July 2005 to reflect the need for treatment at an earlier stage of disease. Persons with advanced HIV include persons with CD4 count <350.

Figure 1: Total Number of HIV, Advanced HIV Cases, AIDS and Deaths Reported, 1982 – 2016



Source: HATS Database, 2016

Figure 2: Annual reported cases of HIV, Advanced HIV, AIDS and AIDS Deaths



	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	00	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16
HIV	1	1	0	9	41	99	77	137	185	331	476	526	594	836	966	1119	1060	1429	1516	1639	1408	1657	1846	1893	2070	1909	1850	1706	1524	1769	1512	1256	1271	1176	2015
Advanced HIV	1	1	0	3	8	34	36	65	70	143	134	219	332	509	488	609	643	890	898	934	973	1054	1108	1327	1181	1083	1194	1474	1490	1241	1870	774	749	640	916
AIDS	1	1	0	3	8	34	36	65	70	143	134	219	332	509	488	609	643	890	898	934	973	1054	1108	1327	1181	774	923	904	927	971	1186	680	535	431	815
AIDS Deaths	0	1	1	0	9	18	21	40	37	105	107	146	199	269	243	393	375	543	616	587	687	652	663	510	431	322	400	380	342	398	256	304	217	261	327

Source: HATS Database, 2016

NEWLY DIAGNOSED CASES

In 2016, 2,015 newly diagnosed cases were reported to the MoH. Approximately 50% of the newly diagnosed cases were for persons diagnosed with CD4 ≥350; this is likely a reflection of scaled-up HIV testing and counselling efforts. However, there is still the need for wider testing as 305 (15%) of these cases were still notified to the National Epidemiology Unit for the first time as deaths.

Persons aged 30-39 years accounted for the largest proportion (25%) of newly diagnosed cases followed by those aged 20 – 29 years old accounting for 23% of the total reported cases.

Figure 3: First Reported & Classified 2016

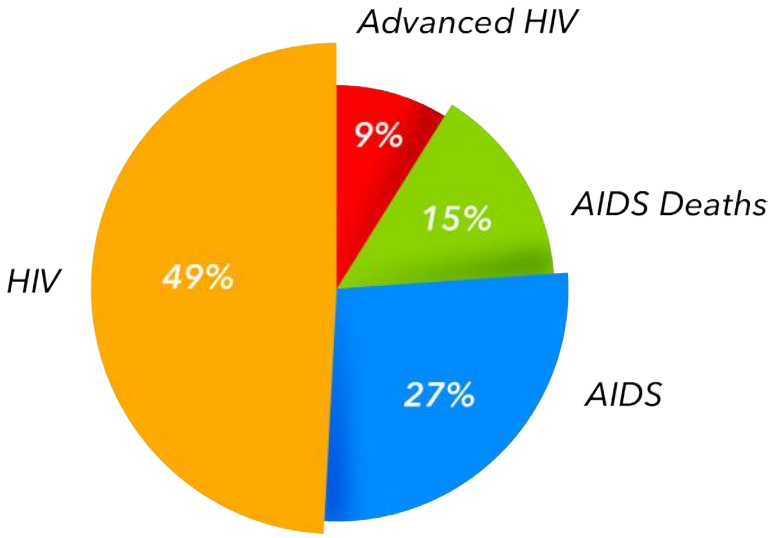
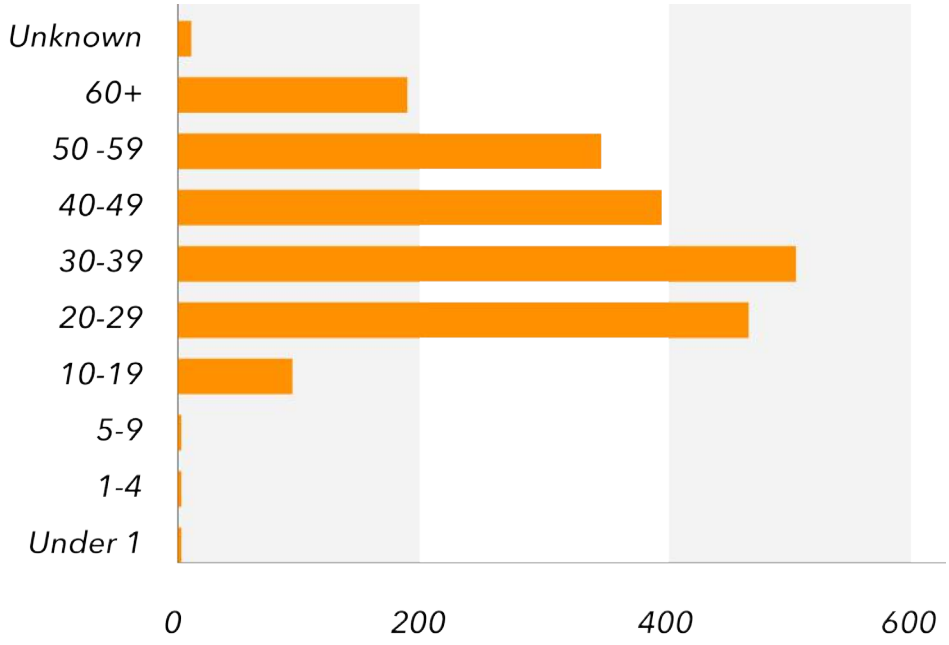


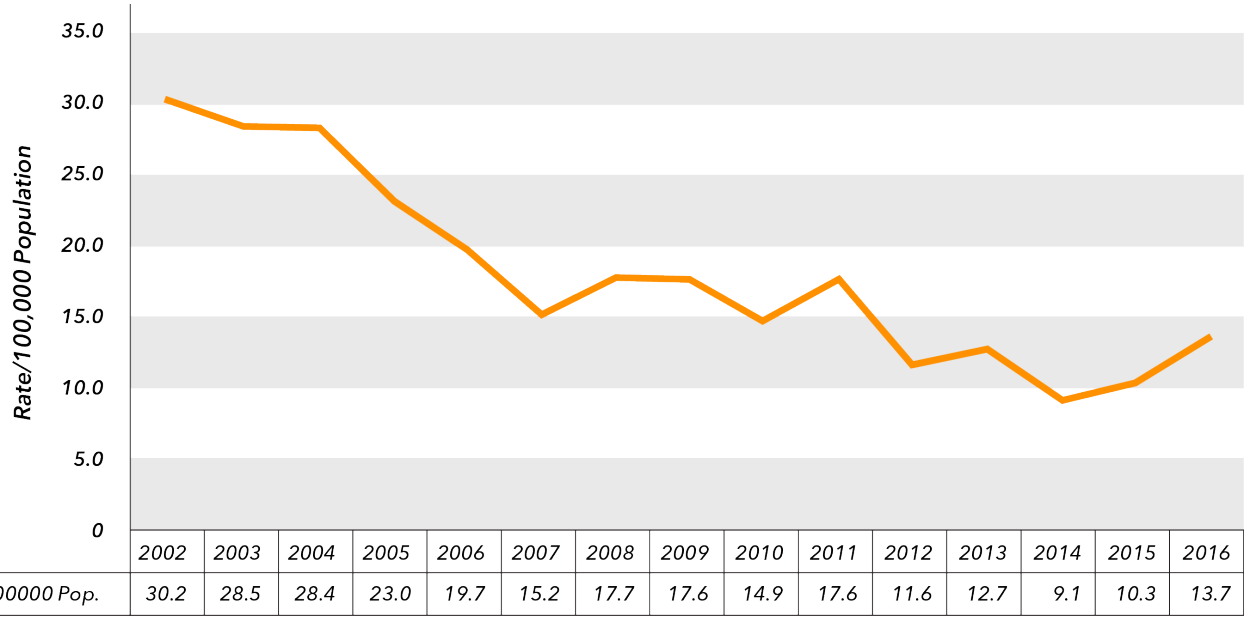
Figure 4: First Reported & Classified 2016



AIDS MORTALITY

Jamaica continues to produce good results in terms of the number deaths averted as a result of AIDS-related illnesses. The AIDS mortality rate declined from 25 deaths/100,000 population in 2004, to just over 13 deaths/100,000 population in 2016; this represents a 48% decline since the inception of universal access to ARVs in 2004. The reduction in deaths can be traced to the introduction of public access to antiretroviral treatment in 2004, the scaling up of the national VCT programme and use of rapid test kits allowing for earlier diagnosis, the availability of prophylaxis against opportunistic infections and improved laboratory capacity to conduct investigations such as CD4 counts, viral load and PCR tests.

Figure 5: AIDS Mortality Rate/100,000 Population, Jamaica 2002 – 2015



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Rate/100000 Pop.	30.2	28.5	28.4	23.0	19.7	15.2	17.7	17.6	14.9	17.6	11.6	12.7	9.1	10.3	13.7

Source: HATS Database, 2016

Although Jamaica has successfully increased access to treatment and care services, analysis of data related to retention in care has shown increased loss-to-follow-up among patients on HAART. Failure to adhere to treatment and care could impact efforts at reducing AIDS morbidity and mortality.

DISTRIBUTION OF HIV IN JAMAICA

Gender

The cumulative male to female ratio for persons reported with AIDS in 2016 was 1.32:1; this ratio is similar to what was reported in 2015, 1.31:1. The cumulative AIDS case rates are higher among males ((27.8 cases per 100,000) compared to females (21.6 cases per 100,000 females). Thus, although the epidemic affects more men than women, over time females are accounting for an increased proportion of the AIDS cases that are reported annually compared with the beginning of the outbreak.

There is also variation in the gender distribution of reported AIDS cases across the lifespan.

Young females account for the larger share of reported cases in the 10 – 29 age range. In the age group 15 to 19 years old, over two and a half times more young women have been reported with AIDS than young men. Similarly, young women aged 20 to 24 years old are one and a half times more likely to be infected than males in the same age group. Adult males account for a larger proportion of the cases reported in the 30 to 79 age group.

However, recent data indicates that the HIV prevalence among young adolescent girls and boys aged 10 to 14 years is estimated to be 0.1%; the infections for this age group are predominantly the result of mother-to-child transmission of HIV (UNAIDS, 2014). In later adolescence (15 to 19 years), there is an estimated increase in HIV prevalence, consistent with the onset of sexual behaviour. By the age of 24, there is a further increase in HIV prevalence consistent with increased sexual behaviour as well as survival and transition of HIV-infected adolescents into the early adult years. Consequently, the estimated HIV prevalence rises to 1% in young women aged 20 to 24 years and to 1.4% in young men in the same the group.

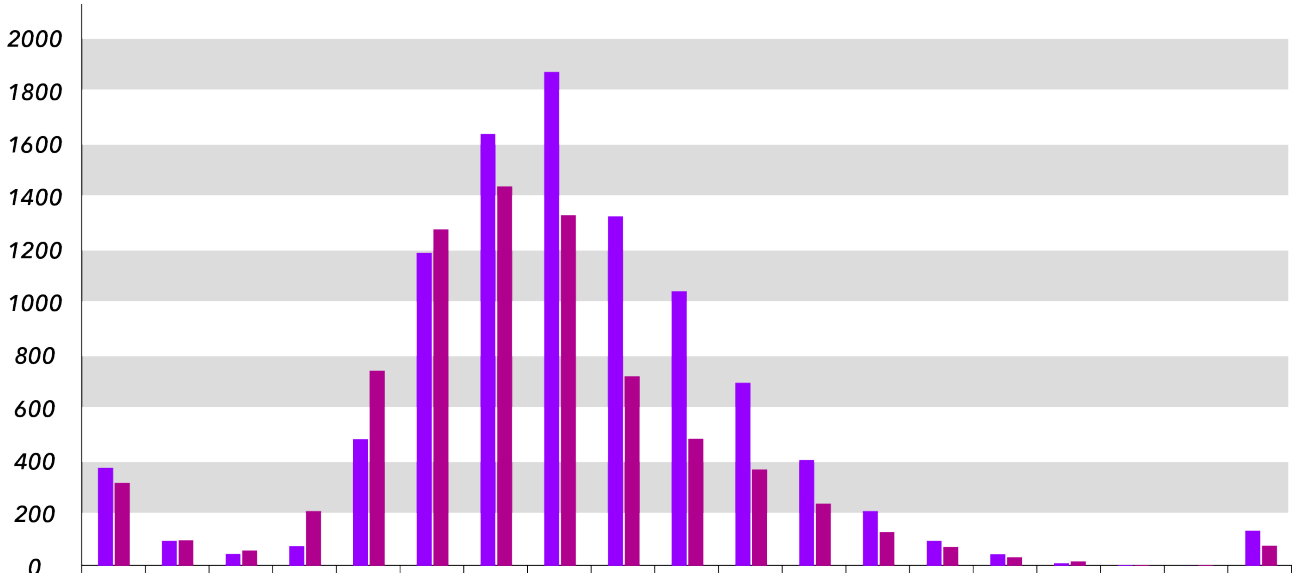
In contrast with the estimated HIV prevalence of 0.4% and 0.5% reported in adolescent girls and boys aged 15 to 19 years respectively, some populations within this adolescent age group are more affected. The HIV prevalence among gay and bisexual adolescent boys is estimated to be 14% while HIV prevalence in transgender adolescents is estimated to be 27% (HIV/STI/Tb Unit, 2014). These figures underscore the extreme vulnerability and urgent need for sustained HIV prevention, treatment, care and support response for these adolescents.

Age

Three quarters (75%) of Jamaicans living with HIV are aged 20 to 49 years old. Cumulatively, there is a steep incline in the number of AIDS cases from 10 – 24 years. The number of AIDS cases reported among 20-24 year olds (1,206) is over four times the number of cases reported among 15-19 year olds (279 cases) which may possibly be due to testing access. Other reasons posited are increased HIV knowledge and acceptance of sexual practices.

The 10-14 age group accounts for 103 cases.

Figure 6: Cumulative AIDS Cases Reported by Age Group and Sex, 1982 - 2016



	0.4	5.9	10.14	15.19	20.24	25.29	30.34	35.39	40.49	50.54	55.59	60.64	65.69	70.74	75.79	80.84	85.89	90.94	Unknwn
Male	367	94	45	74	475	1173	1619	1851	1310	1029	686	397	205	94	44	10	3		132
Female	311	96	58	205	731	1261	1422	1314	710	477	361	233	127	71	32	17	4	3	76

GEOGRAPHICAL AREA

More than half (65%) of the Jamaicans living with HIV currently reside in the most urbanized parishes (Kingston and St. Andrew, St. Catherine, and St. James). This proportion is slightly higher than it was in 2015 (63%), but has decreased from the 2008 figure of 70%.

The most urbanised parishes also have the highest cumulative AIDS case rates: Kingston and St. Andrew – 1,097.1 cases per 100,000 persons, and St. James – 1,531.8 HIV cases per 100,000 persons. Both Kingston and St. Andrew and St. James have cumulative case rates that exceed the national case rate (725.2 cases/100,000 population).

Parishes with significant tourism-based economies have the next highest level of cumulative numbers of reported AIDS cases since the start of the epidemic in 1982: 796.0 cases per 100,000 persons in Westmoreland, 710.9 cases per 100,000 persons in Trelawny, 696.3 cases per 100,000 persons in St. Ann, and 697.7 cases per 100,000 persons in Hanover. Notably, all parishes in the Western Region are among those with the highest cumulative number of HIV cases.

HIV TRANSMISSION CATEGORIES

In Jamaica, HIV is primarily transmitted through sexual intercourse. Among all reported adult HIV cases on for which data about sexual practices are available (78% of cases), heterosexual practice is reported by 95% of persons with HIV.

As has been the case for decades, in 2016, the sexual practices of 33% of men ever reported with HIV and 18% of men reported with AIDS, was unknown. This could be due to inadequate

investigation and reporting of cases as well as an unwillingness among men who engage in sex with other men to disclose their sexual practices.

Of the total number of males reported with HIV in 2016, 3.6% (53) were identified as homosexual and 1.8% (28) identified as bisexual. In 2016, a total of 43 PLHIV (1.5%) reported being a sex worker; of this figure 60% (26 persons) were females and 40% (17 persons) were males.

PERINATAL HIV

In 2016, for every one thousand pregnant women attending public antenatal clinics, approximately seven were HIV infected. Between 1989 and 1996 the HIV prevalence among antenatal women increased from 0.14% to 1.96%. The prevalence has declined over the last 15 years, with the 2014 and 2015 prevalence rates remaining at 1% and below. This overall decline likely reflects the success of behaviour change strategies among the general population.

In 2016, a total of two paediatric AIDS cases (children 0 to 9 years old) were reported compared to 84 paediatric AIDS cases in 2006. This significant decline reflects the success of the eMTCT programme in reaching HIV-positive women.

Table 1: HIV Seroprevalence Rate among ANC Attendees by Parish 2016

PARISH	Total Tested	Total Positive	% Positive	(95% CI) Exact
Kingston & St Andrew	1547	12	0.78	0.40 – 1.35
St Catherine	1161	8	0.69	0.30 – 1.35
St Ann	569	5	0.88	0.29 – 2.04
Clarendon	781	6	0.77	0.28 – 1.66
St James	464	4	0.86	0.24 – 2.19
Westmoreland	695	4	0.58	0.16 – 1.47
TOTAL	5217	39	0.75	0.53 – 1.02

Source: Sentinel Surveillance, 2016

One paediatric AIDS death was reported in 2015, compared to 16 in 2005. This represents a 93% decline in the number of paediatric AIDS deaths over this period.

RISK BEHAVIOURS AND OTHER FACTORS FUELLING THE EPIDEMIC IN JAMAICA

Jamaica continues to exhibit features of both a generalized and concentrated HIV epidemic. The prevalence in the general population is estimated at 1.7%, however surveys show higher HIV prevalence in at-risk groups.

The main risk factors fuelling the epidemic in Jamaica include multiple sex partners, history

of STIs, crack/cocaine use, and sex with sex workers. 'No high risk behaviour' was reported for a significant proportion of HIV cases and this may represent persons who have one sex partner who was HIV infected by another partner.

Table 2: Annual Reported risk behaviours among adults with HIV (1982 – Dec 2016 cumulative)

Risk	No. of persons (%) 2016	No. of persons (%) 1982-2016
History of STI	438 (16%)	11691 (19%)
Multiple Sexual Partners/ contacts	509 (18%)	5500 (9%)
Sex with Sex workers	186 (7%)	4492 (7%)
No high-risk behaviour	1 (0.04%)	4939 (8%)
Crack, Cocaine User	28 (1%)	1396 (2%)
IV Drug Use	7 (0.3%)	206 (0.3%)

Data from surveillance of STI clinic attendees in 2016 indicated that for every 1,000 persons with a sexually transmitted infection, approximately 32 were infected with HIV. Further, 67% of STI attendees tested in the sentinel surveillance were females – 2.03% of these females tested positive for HIV compared with 4.6% of male STI attendees.

Table 3: HIV Seroprevalence Rate Among STI Clinic Attendees by Parish 2016

PARISH	Total Tested	Total Positive	% Positive	(95% CI) Exact
Kingston & St Andrew	1291	63	4.88	3.77 – 6.20
St Catherine	332	9	2.71	1.25 – 5.08
St Ann	617	7	1.13	0.46 – 2.32
Clarendon	245	2	0.82	0.10 – 2.92
St James	283	10	3.53	1.93 – 6.38
Westmoreland	38	1	2.63	0.07 - 13.81
TOTAL	2806	92	3.28	2.65 – 4.01

CHAPTER 2: PREVENTION AND SEXUAL AND REPRODUCTIVE HEALTH

INTRODUCTION

In 2016, the Prevention Unit's work focused on three key populations: men who have sex with men (MSM), sex workers (SW) and transgender persons (TG). In addition to its work with key populations, the Prevention Unit also worked with the general population and other vulnerable populations such as inmates and adolescents. The Unit's interventions for these key populations included outreach activities, distribution of condoms and lubricants and skills-building activities.

One of the priorities of the HIV/STI/Tb Unit (HSTU) is increasing access to HIV and Syphilis testing. This work was led by the Prevention Unit at the NFPB and done in collaboration with the RHAs

HIV and Syphilis Rapid Testing and Outreach among Key Populations

In 2016, 4014 MSM were reached through the efforts of the Prevention Unit and its partners. This figure represents 75% of the Unit's target of reaching 5348 MSM. The Unit's target for 2016 was to test approximately 40% of MSM reached (1606). The Unit tested 1602 MSM, just four persons short of its target.

The Unit's efforts to target the transgender population is in its initial stages. In 2016, the Unit reached 301 persons in this key population and was successful in testing approximately 23% of them (69 persons).

With respect to female sex workers, 8797 women were reached and 3390 (or 39%) were tested.

Table 1. Total Number of Key Population Reached and Tested in 2016

Entity	MSM Reached	MSM Tested	TG Reached	TG Tested	FSW Reached	FSW Tested
NFPB	578	327	16	7	1066	585
NERHA	229	133	21	7	813	309
SERHA	1337	383	118	45	2396	514
SRHA	331	139	7	2	1382	667
WRHA	1539	620	139	8	3140	1315
Total	4014	1602	301	69	8797	3390

Of the three key populations, transgender persons proved hardest to self-identify, reach and test. This is an area of concern that will be explored further so as to establish commonalities within a strategy to identify, reach and test transgender persons.

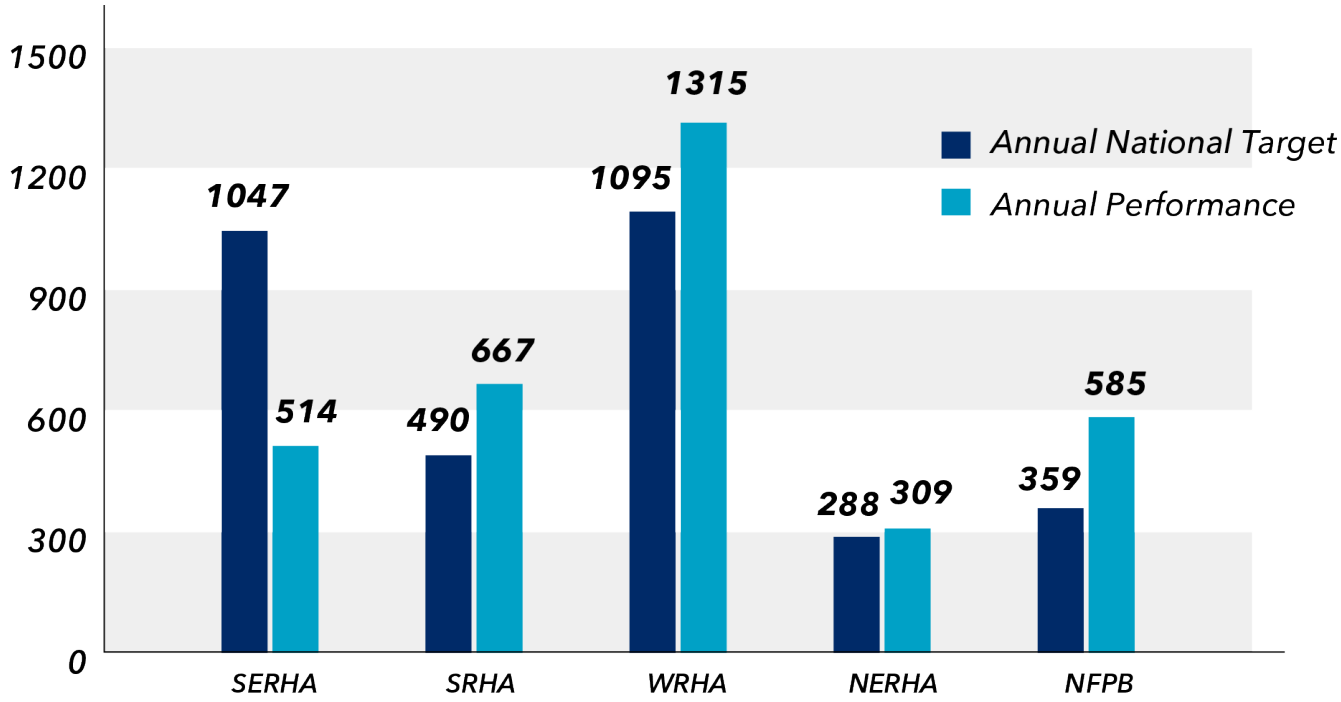
HIV Prevention for Female Sex Workers (FSW)

In the reporting year, the national testing targets for FSWs in each region, excepting The South East Regional Health Authority (SERHA), were surpassed.

The main strategy utilised was to 'reach and test'. The Unit acknowledged that it experienced limitations in the number of FSWs it was able reach. The factors that contributed to the decline in the number of FSWs being reached include: sex workers travelling to different Caribbean islands for work and an increase in home-based sex work (which means fewer FSWs can be found at the targeted outreach sites).

In previous years, the prevention programmes that targeted FSWs included skills-building and empowerment workshops. These interventions were designed to increase FSWs' knowledge, skills and self-confidence to enable them to make informed decisions about their sexual health and wellbeing. However, empowerment and skills-building workshops were discontinued due to a significant reduction in funding.

Figure 1. Female Sex Workers Tested in Comparison to Targets



Nonetheless, successful attempts have been made by various organizations to maintain aspects of the prevention programme with sex workers despite limited funding. The Southern Regional Health Authority (SRHA) and SERHA for example led efforts to increase awareness amongst FSW about sexual reproductive health issues such as cervical cancer. A total of 400 FSWs received pap-smears across both regions, with SERHA providing the majority of pap-smears examinations (300).

Considering the challenges, the Unit pursued other strategies such as the Peer-link Strategy and Community-based Interventions. Through their sex-workers' community-based interventions, the North East Regional Health Authority and the South East Regional Health Authority identified females engaging in sex work from their homes. The RHA teams sought to equip these FSWs with information on sexual reproductive health such as risk assessment and risk reduction, family planning, prevention of unwanted pregnancies and STIs.

Overall, the challenges in reaching the FSWs include:

1. Duplication of efforts. The population is transient; therefore, it is likely that there are several agencies reaching and testing the same individuals.
2. Identifying new sex work sites. New FSWs are becoming more difficult to identify at the traditional sex work sites such as massage parlours and clubs.
3. Emergence and identification of new types of sex work sites. FSWs have found creative ways of eliminating additional costs associated with the services they provide. For example, sex workers are now operating out of their homes and this presents a challenge to reach and test significant numbers of FSWs.

4. Use of new technologies. The proliferation of social networking allows FSWs to connect with their clients virtually, instead of being on the streets and the clubs.
5. Funding for FSW Intervention: Incentives such as care packages are useful in encouraging FSWs to utilize the other services that RHAs offer such as HIV/Syphilis testing. Funding is also necessary to assist FSWs with other psychosocial needs. With the elimination of empowerment workshops FSWs are of the assumption that there is only the need to reach and test them.

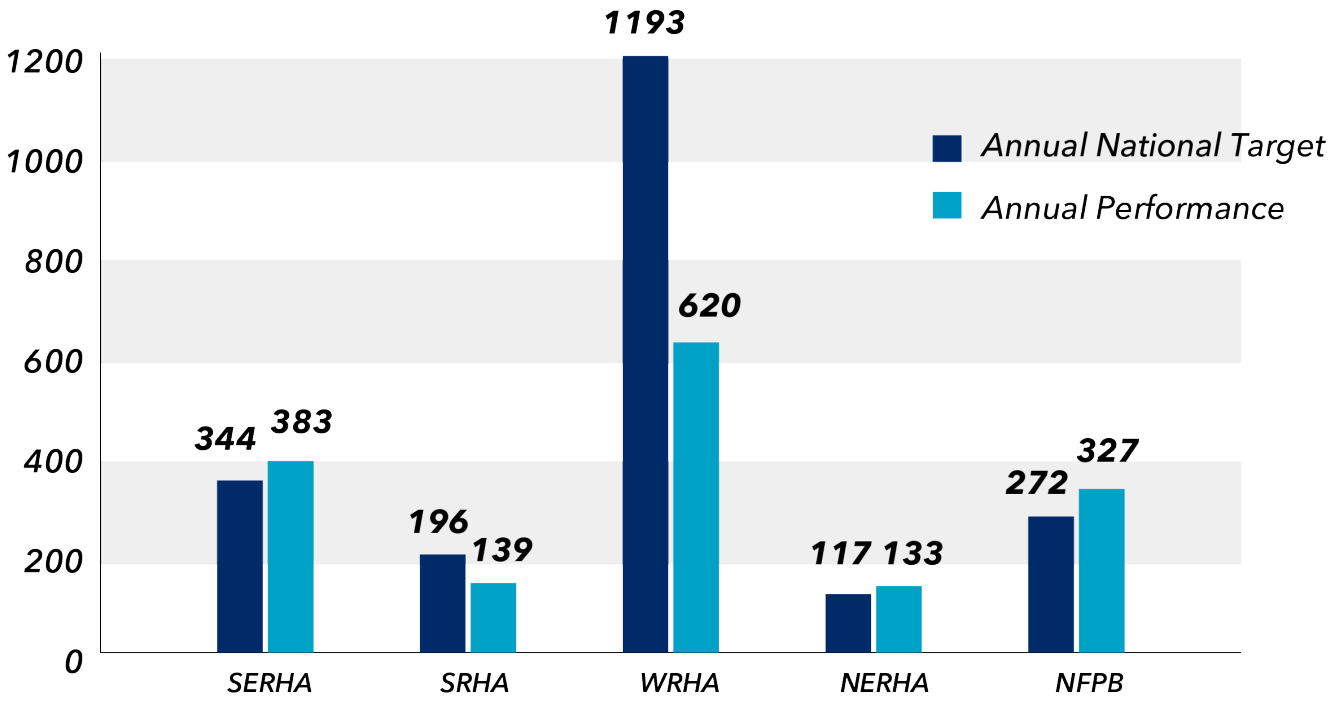
The Unit has identified the following approaches as being critical in moving the work forward:

1. Identify and conduct interventions at non-traditional sex sites. Moving from traditional venues to other sites where sex workers operate such as dances, parties and bars.
2. Increased partnership with members of the FSW population: Continued dialogue with members of the FSW community to better understand their needs and to improve service delivery.
3. Engagement of Peer Links: Increase the number of sex worker peer-links who are informed of their peers' whereabouts and needs.
4. Reintroduce empowerment sessions and skills-building activities to engage FSW. Identify specific topics and skilled areas to cover that will prove beneficial to FSWs.

HIV Prevention for Men who have Sex with Men (MSM)

In 2016, the Unit reached 4014 MSM and tested 1602 MSM.

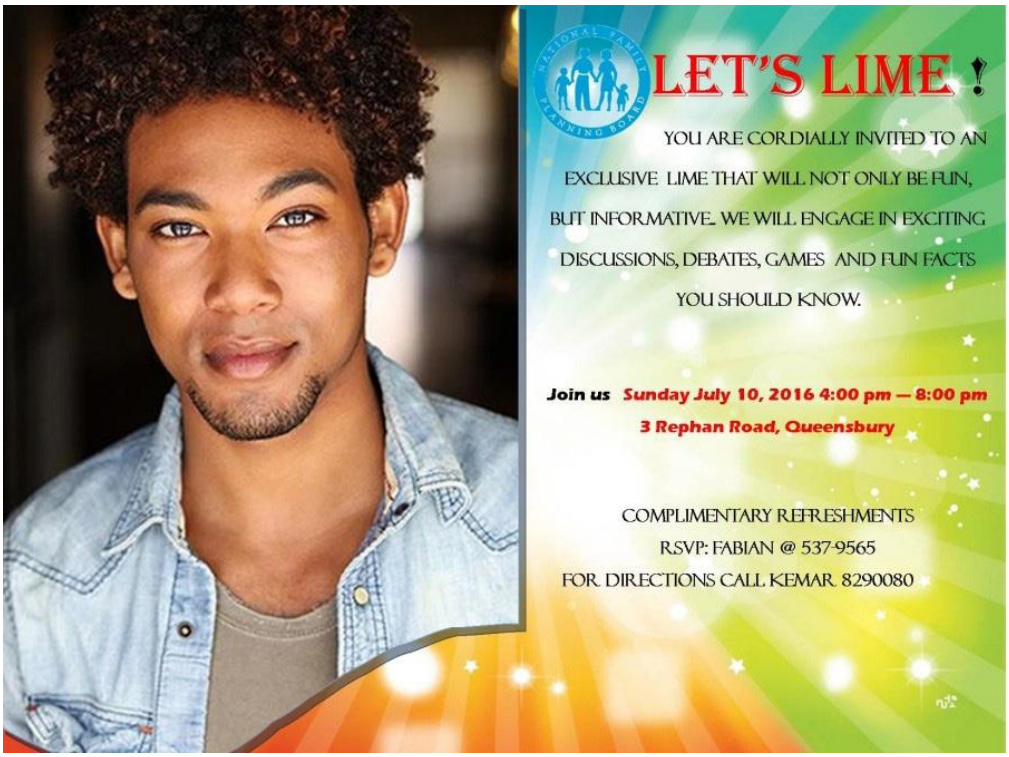
Figure 2. MSM Tested in Comparison to Targets



The unit employed various strategies to reach this key population; they included:

1. Home-based interventions (HBI). The home-based sites are also known as "lymes" or "hang-outs". They are private and comfortable spaces for the MSM that allow for the Unit to provide its services. The lymes incorporate social activities such as games and they have attracted a wider cross-section of MSM/TG. The HBI-format represents a revision of the previously used workshop strategy and includes the revision of the content that is presented to MSM. The topics, such as HIV Basic Facts, STIs, Anal Care, Risk Assessment/ Reduction and Adherence are presented in a concise and exciting format. The sessions are aimed at building trust and expanding networks through snow-balling and social media integration. Figure 3 below illustrates an invitation flyer for a Lyme that was hosted in the reporting period.

Figure 3: Invitation Flyer, "Let's Lime"



2. Venue-based Intervention (VBI). This type of intervention provides an opportunity for the Unit to continue to engage with the MSM that were part of the HBIs, with the aim of promoting and maintaining safer sex practices among MSM. The VBIs therefore are an avenue for enhancing the information imparted to MSM/TG who are negative, to reinforce the concept of staying negative.
3. Skills-training & capacity-building. The skills-training sessions are aimed at providing MSM with the practical skills that they can use to promote their empowerment, to become self-sufficient and demonstrate self-efficacy. The skills areas that the MSM had the opportunity to take advantage of included: Bartending, Make-Up Artistry and Graphic Design, CXC subjects, Food Preparation, Customer Service, and Resume Writing. This

strategy expanded the team's network, making them more visible for not only providing HIV Testing but for impacting the lives of MSM holistically.

4. Supporting MSM events and parties. The use of this strategy is an acknowledgement that it is important to engage with MSM in their own social spaces, where they are most comfortable. Through sponsorship, donations or ticket sales, the Unit is able to gain entry to the events and parties. The event promoters serve as gate keepers and are in support of these initiatives. They, at times, refer persons to be tested. The social events are also an opportunity for the prevention teams to recruit persons for HBIs.
5. Social media networking through MSM dating sites. Through the use of popular MSM Dating sites such as: Jack'd, Grindr, Adam4Adam and LGBT Groups on Facebook and WhatsApp, the prevention teams are able to network and build relationships with various social classes of MSM in order to recruit for HBIs. The prevention team's strategy is to create personal profiles and make a "human" connection. Further to establishing a connection, the prevention team uses the opportunity to build relationships and refer individuals for additional services.
6. Utilizing peer links for networking. The prevention team identified, recruited and deployed individuals that it identified as influencers within the LGBT and FSW community as peer links. The peers host site-based interventions and provide referrals of other MSM and FSW. This strategy has been successful in mobilizing persons to participate in site based interventions.
7. MSM Tool-Card distribution. Outreach Officers/Community Peer Educators are equipped with personalized information cards that resemble a small business card with contact information that allows MSM and men to easily communicate with staff through private and confidential contact telephone calls, text messages and WhatsApp conversations. These cards are distributed by staff during all interactions with men at condom distribution sites, parties, men's clothing stores and teen hubs. Cards are also available through guidance counsellors. The lines are warm, as they are opened between 8:30a.m and 10:00 p.m. daily and the response time is quick.

Figure 4: Men's Tool Card

Best Practice

Through its work in 2016, the Unit identified three key best practices to mobilize the MSM population for prevention interventions; they were:

1. The use of the Men's Tool Card
2. Creating an attractive flyer or invitation appeals to MSM and TG persons allowing for a higher yield for interventions
3. Capitalizing on Social Media platforms

Challenges

The Unit faced several challenges in 2016; some of which include:

1. Migratory nature of MSM. The population, like FSWs is transient, hence this results in duplication of efforts by service providers as they are likely reaching the same persons in a given week or month.
2. Violence. Some members of the population are identified as the perpetrators of violent acts, while others are victims of violent acts. Incidence of violence is particularly high in urban areas. Threats of violence among the MSM population sometimes disrupts interventions and also compromise the safety of staff.
3. Incentivized participation. The population have become accustomed to receiving stipends for participating in programmes and have become unwilling to participate in interventions unless monetary incentives or care packages are being offered.
4. Stigma associated with sexual orientation. Jamaica's legislation around the Buggery Act contributes to the discrimination faced by members of the MSM community. This in turn forces them underground and prevents them from accessing much needed health and social support.

Based on its experience with implementing prevention programmes for MSM, the Prevention Unit identified the following key next steps for working with the population:

1. Review and revise strategies. In the absence of increased funding, there is a need for new and creative ways to reach the MSM and TG populations. This can be done through working with members of the population and allowing them to be a part of the decision-making process.
2. Maintain communication with members of the MSM population and key LGBT groups. Continued dialogue with members of the MSM community to better understand their needs and to improve service delivery.

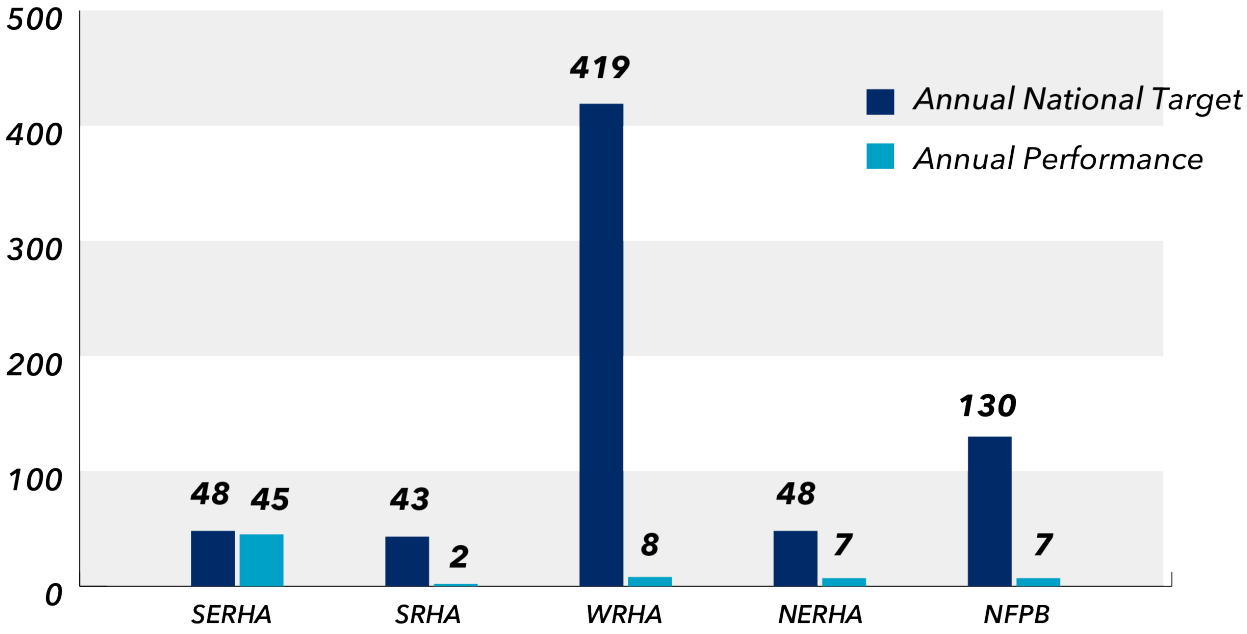
HIV Prevention for Transgender Persons (TG)

Reaching and testing members of the TG community remains a challenge for all entities. The annual performance targets for reach test, 301 persons and 69 persons respectively, fell significantly below the national targets of 894 persons (reach) and 688 persons (test), as illustrated in Figure 5.

Given that working with TG is new territory for the outreach team, the National Programme invested in several capacity building activities during the reporting period. These training

sessions assisted the officers to develop a better understanding of working with persons whose biological sex is different from their gender identity.

Figure 5. Number of transgender persons tested in comparison to targets, 2016



Jamaican's cultural norms are highly aligned with the Christian norms and practices. Additionally, social norms and practices are highly heteronormative; thus the environment is not conducive to gender expressions that do not relate to one's biological sex. It is therefore difficult for the outreach teams to identify TG persons as persons are fearful of being the victims of violence or discrimination.

The strategy for targeting transgender persons is yet to be defined by the Prevention Unit. Nonetheless, in 2016 the RHAs utilized the peer link strategy to reach members of the TG community. The South East Regional Health Authority (SERHA) held a two-day workshop with 40 members of the community from KSA, St. Catherine and St. Thomas.

Overall, hesitation on the part of members of the TG Community to disclose their identity poses challenges for the implementation of outreach initiatives. While some persons are hesitate to identify all together, the Unit has observed that some persons who may be presumed to be TG, identify as MSM. Target setting for outreach initiatives for example is difficult to do without an understanding the profile of the key population. The outreach team identified possible solutions for reaching the population; they include:

1. Build capacity of the BCC Teams and health care workers (doctors, nurses, phycologists) to better understand Sexual Orientation Formation of LGBTQI.
2. Form a Prevention Technical Working Group that will include TG persons to develop comprehensive national strategies to reach members of the TG community.
3. Develop relationships with international partners (regional) to build capacity and learn their best practices.

HIV Prevention Programmes in Correctional Institutions

Prevention interventions were carried out in five (5) adult correctional institutions throughout the year: Tower Street Adult Correctional Centre (TSACC), St. Catherine Adult Correctional Centre (ST. CACC), Fort Augusta Adult Correctional Centre (FAACC), Horizon Adult Remand Centre (HARC), and Tamarind Farm Adult Correctional Centre (TFACC).

The objective of the Sexual and Reproductive Health Programme in the correctional institutions is two-fold: 1) to identify and provide treatment and care for sexually transmitted infections (STI), specifically Syphilis, HIV and Hepatitis B, and 2) to assist the Department of Correctional Services with healthy lifestyle initiatives for the incarcerated population. Screening for HIV and other STIs is offered upon intake of all new inmates, and those currently housed in correctional institutions. The provision of treatment for STIs, including antiretroviral therapy and adherence support are offered to HIV positive inmates.

In 2017, 1,675 inmates were reached through the Unit's prevention activities. Close to all of those reached in 2016 were tested, 1,598 for HIV (95%) and 1,575 for syphilis (94%). The outreach team recorded thirty-six (36) positive cases for HIV and 22 reactive cases for syphilis. One hundred and twenty-nine (129) PLHIV received follow-up care such as CD4 and viral load testing, as well as adherence counselling.

Throughout the period 230 correctional officers were also engaged in sensitization sessions geared at providing knowledge about HIV/AIDS, eliminating the stigma and discrimination associated with the disease, and promoting a healthy lifestyle.

Working with this vulnerable group presents unique challenges. These include:

1. ***Prohibition of condom distribution in Correctional Facilities:*** Although it is known that inmates are engaging in sexual activity, officers working with inmates are not allowed to provide them with condoms.
2. ***Administration of PEP in Correctional Facilities:*** The Post-Exposure Prophylaxis (PEP) Guideline, states that only victims of sexual assault should have access to PEP. However, persons are being exposed to HIV within the institutions and should be able to access PEP. One solution is to provide PEP for Key Populations within institutions.

HIV Prevention Programmes for Adolescents

Out of School Youths

The out of school youth population has access to a standard package of services which includes: free HIV and Syphilis screens, risk reduction assessments and reduction conversations, condom demonstrations, STI/HIV/AIDS conversations, condom demonstrations and distribution.

In 2016, the Prevention Unit reached 21,368 persons ages 15 to 29 years and tested 2,337 (11%) of them. Unfortunately, there are no funds available to implement other interventions

such as empowerment workshops and training sessions for individuals from this population.

General Population Interventions

Peer Navigation System

The Peer Navigation System was introduced in 2016 to improve the ratio of persons diagnosed to the number of persons linked to care. At the end of 2016, 120 Peer Navigators were trained and deployed across the RHAs and the CSOs. A protocol on how peer navigators out to engage with persons who are newly diagnosed with HIV, was also developed and validated.

Themed Events

The National HIV/STI/Tb Unit commemorates three annual special events. These special events are Safer Sex Week during Valentines Week, Regional Testing Day (the last Friday in June) and World AIDS Day on December 1 each year. These events are essential to normalizing testing and creating awareness around HIV transmission, condom use and other sexually transmitted infections (STI).

Safer Sex Week

Safer Sex Week (SSW) was observed during the period February 8-16, 2016. To commemorate the week, the Unit executed several activities under the theme: 'Lovin' tun up, when condom show up!'. The activities included a national event hosted at Mandela Park, sensitization sessions on safer sex with government workers, a public lecture and a panel discussion by sexologist Dr. Karen Carpenter. The main focus of the various activities was to reinforce the message of safer sex and dual method use.

Building condom use skills

Outreach testing in Kingston

At the national event hosted at Mandela Park in Kingston on February 12, 416 persons (253 females and 163 males) were tested for HIV and Syphilis. In addition to testing services, condoms, two other contraceptive methods injection and pills were distributed. Although, the injection and pills were available to the participants, the uptake was low. Only 22 women accepted the contraceptive injection (Depo Provera) and 33 accepted the oral contraceptive pill (Microgynon). The uptake of condoms on the other hand was significantly greater, with 2,114 condoms were distributed.

Regional Testing Day

Regional Testing Day (RTD) was observed during the period June 17-31, 2016. The activities were executed under the theme: "RU+ RU-" (Are you positive, are you negative?). The theme was phrased as a question with the aim of getting persons to actively think about their status and to get tested.

Over the two week period, 1,210 persons were tested at 15 sites across the island

Regional Testing Day, Half Way Tree St. Andrew

Field Coordinator at work in Half Way Tree

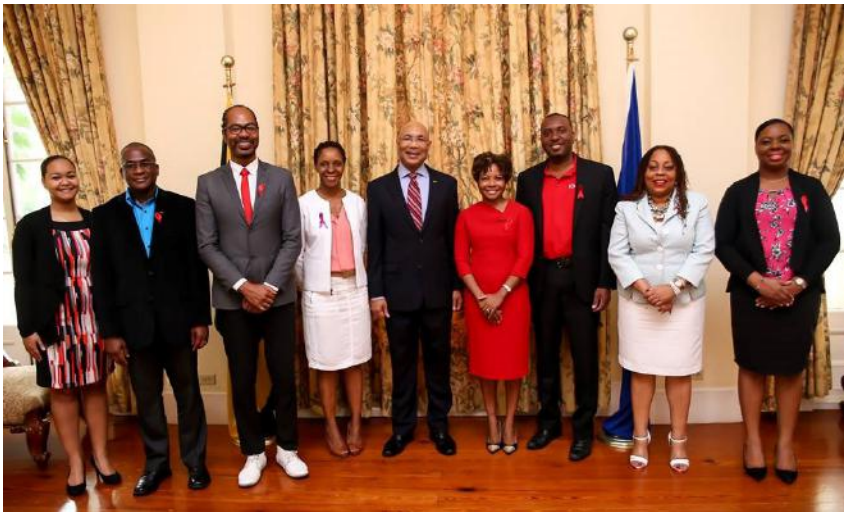
Taking the service to the population, Limelight Plaza, Kingston

World AIDS Day

For the observance of World AIDS Day 2016, the UNJT on AIDS provided support to the National Family Planning Board in its launch of the HIV prevention campaign. The campaign was successful in reaching over 200,000 persons via social media and other media outlets. The hashtags #HandsUpJa, a local take on the #HandsUpforPrevention were used for the campaign. The national event was held in Kingston and included a road march from Cross Roads to St. William Grant Park, a stage show and an outside broadcast, sponsored by AIDS Healthcare Foundation.

Those who participated in World AIDS Day events across the island accessed HIV/Syphilis screening, Pap smears, condoms and other contraceptive methods. Through the Unit's outreach, 1784 persons (694 males and 1090 females were tested for HIV and Syphilis. The women present accessed Pap smear services (30 persons), 45 accessed contraceptive pills and six (6) received the contraceptive injections. Pap smears and contraceptive services were only offered in Kingston.

Signing the proclamation,
Kings House



WAD Church Service,
Christ Church, Kingston

HIV Screening,
St. William Grant Park

Road march, Crossroads to Downtown Kingston

Next Steps – Key Population Participation

The National Programme team continues to identify ways in which it can improve access to HIV Testing and Counselling (HTC) services among KPs. Strategies for consideration include:

1. ***Creating a National Transgender Strategy*** – Given that the targeting of this this key population group is new for the National Programme and experience with implementing initiatives for TG in 2016 highlighted several challenges, a strategy will bolster efforts to effectively target this population.
2. ***Strengthening the synergies between Prevention and Treatment*** – Given that prevention is the first step in the treatment process, it is important to strengthen the relationship between both, for the benefit of the clients and for the achievement of the 90-90-90 target.

CHAPTER 3: TREATMENT, CARE AND SUPPORT

OVERVIEW

The Treatment Care and Support Unit is the technical arm of the National HIV/STI/Tb Unit (HSTU). The unit's goal is to manage the HSTU programmes to ensure universal access to treatment, care and support services. To that end, the unit's targets for the 2014-2019 period as outlined in the National Integrated Plan for Sexual and Reproductive Health are:

1. By 2015, eliminate vertical transmission of HIV and Syphilis by 2015
2. By 2019, increase coverage of ARV treatment for PLHIV to 65%
3. By 2019, reduce the number of HIV related deaths by 25%
4. Increase to 90% the proportion of PLHIV on ART one year after initiating therapy

Since the introduction of ARVs in 2004, the vertical transmission of HIV has virtually been eliminated and there has been a 76% reduction in AIDS-related mortality. However, there are still some major challenges with respect to scaling the national response. These challenges include:

1. Too few PLHIV being aware of their status
2. Suboptimal rates of linkage and retention in care
3. A lag in ARV coverage for those who are eligible
4. Low viral suppression levels.

Globally, Sexually Transmitted Infections (STIs) are the third most common cause of loss of healthy life years for women of reproductive age. In the Jamaican context, with respect to TB for example, the case detection rates over the 25-year period 1990-2014, have ranged from 48% in 2014 to 79% in 1990.

The HSTU programme has outlined the following objectives to address STIs:

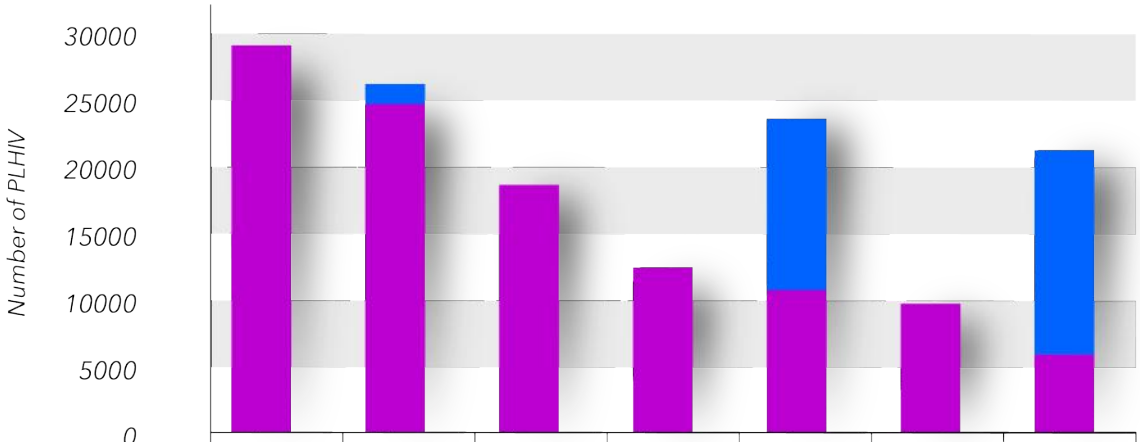
1. Update and improve treatment guidelines and capacity building
2. Improve accessibility to diagnosis and monitoring of HIV at point of care
3. Improve supply chain management
4. Provide appropriate and accessible services

CONTINUUM OF CARE

The gaps in the continuum of care continue to hinder the national response to HIV/AIDS. The specific challenges include linkage to and retention in care, shortfalls in ARV coverage and viral suppression. Barriers to care such as stigma and discrimination, staff shortages, inadequate linkages with civil society and private sector organizations further widen the gaps that exist in the continuum of care.

The national treatment cascade (Figure 6), demonstrates the extent of the deficiencies in the continuum of HIV treatment and care.

Figure 6: National treatment cascade

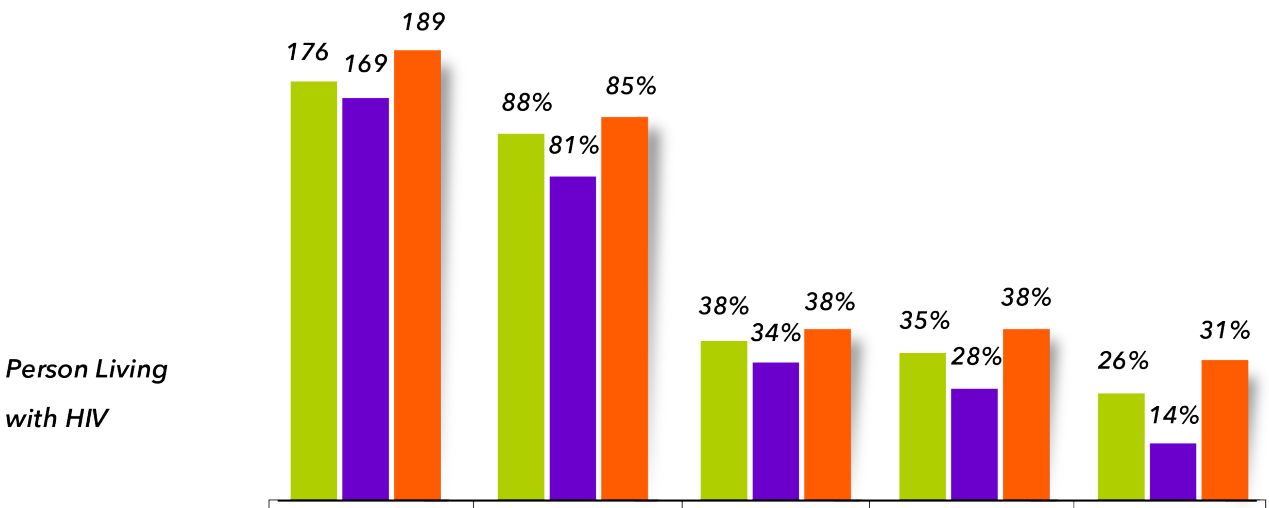


	Total PLHIV Estimated	PLHIV Diagnosed	PLHIV Ever Linked to Care	PLHIV Retained in Care	PLHIV Retained on ARV	PLHIV With Recent VL Test Done	PLHIV Virally Suppressed
Additional Amount needed to reach 90-90-90		1492			12810		15300
2016	29000	24608	18556	12360	10680	9662	5841

The national programme estimates that in 2016, there were 29,000 individuals living with HIV. Of that figure, approximately 85% have been diagnosed. An estimated 75% of persons who are diagnosed with HIV are linked to care; of those who are linked to care, 67% have been retained in care.

The cascade of treatment for key populations shows that while a greater number of homosexuals are linked to care when compared to bisexual men and female sex workers, the rates of retention in care are highest for bisexual men. The prevalence of PLHIV on ART, the prevalence of viral load testing and the viral suppression is lowest amongst female sex workers (whose prevalence of HIV infection is 2%) and highest amongst the homosexual population.

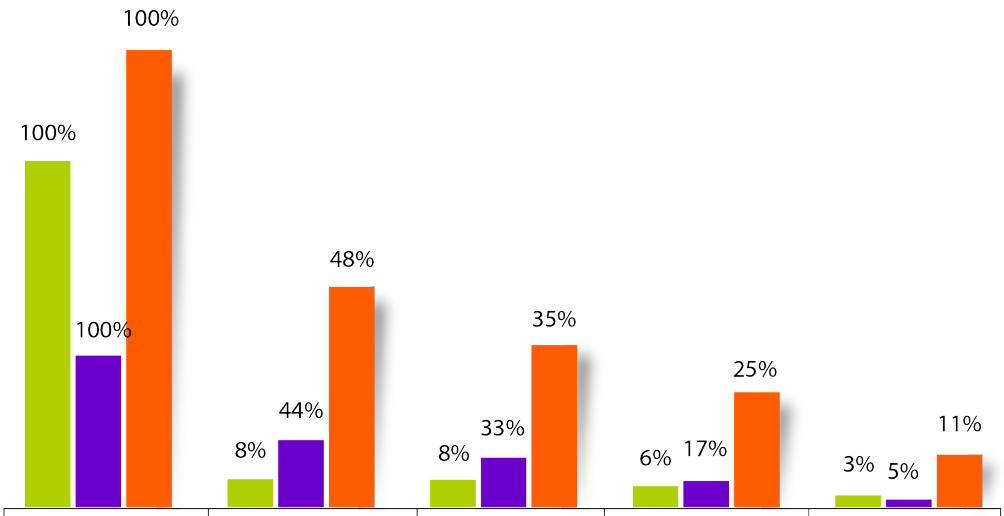
Figure 7: Key Population National HIV Treatment Cascades, Jamaica 2016



	PLHIV Linked	PLHIV Retained	PLHIV or ART	Load test done	PLHIV virally suppressed
Bisexual (males)	176	154	67	62	45
Female sex worker	169	136	58	47	24
Homosexual	189	161	72	72	59

With respect to the youth and adolescent populations living with HIV, approximately three times as many persons between the ages of 20 and 24 years are linked to care when compared with those who are 15 to 19 years old. At least twice as any persons aged 10 to 14 years are linked to care when compared with those 15 to 19 years of age. For those aged 10 to 14 years however, the prevalence with which they are retained in care is considerably lower than those 15 to 24 years old. The trend continues along the continuum of care for those 10 years to 14 years, where the cascade shows that prevalence of viral load testing and viral suppression lag behind the other age groups.

Figure 8: Youth and Adolescent Treatment Cascade for 2016



	PLHIV Linked	PLHIV Retained	PLHIV or ART	Load test done	PLHIV virally suppressed
10-14 years	176	154	67	62	45
15-19 years	169	136	58	47	24
20-24 years	189	161	72	72	59

HIV TESTING

The HSTU monitor testing is done both at private and public laboratories. In 2016, approximately three times as many HIV tests were done at public health facilities (136,286 tests) when compared with those done at private laboratories (47,330).

Table 2(a) illustrates that testing data received from 6 of 14 private laboratories across the island. In 2016, 47,330 HIV tests were done at private laboratories; of that number, 368 (0.8%) returned HIV positive results.

Table 2a: HIV Testing done in the Jamaican Private Laboratories, January to December 2016

Month	Number of HIV tests done	Number of HIV positive test results	Percentage of HIV positive test results
January	4,672	42	0.9
February	4,339	48	1.1
March	5,099	46	0.9
April	5,234	44	0.8
May	3,548	35	0.9
June	4,824	30	0.6
July	4,122	23	0.6
August	3,426	19	0.6
September	4,690	24	0.5
October	3,946	17	0.4
November	700	20	2.8
December	2,730	20	0.7
Total	47,330	368	0.8

**HIV testing scaled down significantly in WRHA for the period Aug-Dec 2016*

Six (6) of the 14 private labs reported for all months. For the month of November only three (3) labs reported.

Table 2(b) illustrates that testing data received from public health sector in 2016. In the reporting year, 136,286 tests were conducted, of which 2% yielded HIV positive results.

Table 2b: HIV Testing in the Jamaican Public Health Sector, January to December 2016

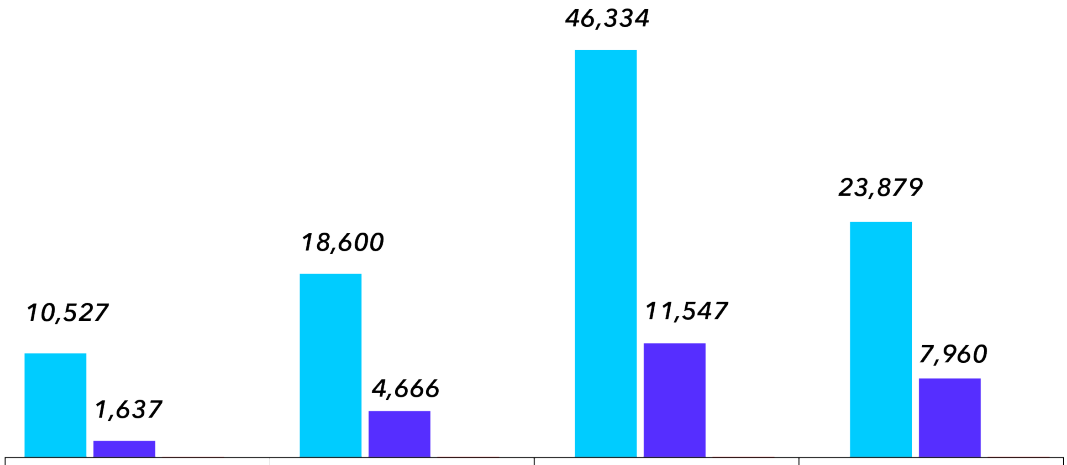
Month	Number of HIV tests done	Number of HIV positive test results	Percentage of HIV positive test results
January	10,404	226	2.2
February	13,345	240	1.8
March	11,090	232	2.1
April	11,104	227	2.1
May	13,782	277	2.0
June	15,236	329	2.2
July	14,640	286	1.9
August	9,994	158	1.6
September	7,037	152	2.2
October	7,182	140	1.9
November	12,403	276	2.2
December	10,069	223	2.2
Total	136,286	2,766	2.0

**HIV testing scaled down significantly in WRHA for the period Aug-Dec 2016*

Provider Initiated Testing and Counselling (PITC)

In 2016, the HSTU continued its efforts to build the capacity of health care workers in the public health facilities and in civil society organizations to conduct PITC. During period under review, four trainings were conducted in three health regions, one in the North East and Western regions and two in the South East region. Across the four training sessions, the HSTU trained 78 persons. The training participants included f health care workers such as nurses, midwives, clinicians and community health aides and individuals from non-governmental organizations that are serving the wider population and key HIV/STI populations. In 2017 the HSTU intends to conduct a PITC training of trainers' sessions so as to build the capacity of the regions to routinely conduct their own PITC trainings.

Figure 9: PITC Uptake in Jamaican Hospitals January to December 2016



	WRHA	NERHA	SERHA	SRHA
#of Admissions	*10,527*	*18,600*	*46,334*	*23,879*
Admissions Tested	*1,637*	*4,666*	*11,547*	*7,960*
PITC Uptake(%)	*16*	*25*	*28*	*33*

In 2016, the uptake of PITC was highest at SRHA, at 33% of admissions being tested, though this represents a 3% decline when compared with 2015 figures. The Western Regional Health Authority (WRHA) recorded the lowest uptake. The PITC uptake for WRHA is similar to what was recorded in 2015[1] . For the SERHA 16% of admissions were tested, an increase of 1% when compared with 2015. The uptake of PITC at the North Eastern Regional Health Authority (NERHA) was 25%; this represents a 9% increase when compared with the 2015 uptake figures.

TREATMENT

Access to ARVs

In 2016 the HSTU experienced stock out and low stock for a number of ARVs. The factors that influenced the stock numbers included a protracted internal procurement process, and delays in the assigning of a budget due to the General Election. As a result, pharmacies were required to share supplies within and between regions with some patients being given partial refills and other patients being switched to alternate regimes.

In 2016, the submission of monthly ARV usage reports from pharmacies that dispense ARVs was tardy, with less than 50% submitting their reports. The total number of patients served

[1]With respect to PITC in the western region, it should be noted that the Cornwall Regional Hospitals had drastically scaled down its activities due to environmental issues being faced at the facility; as such, no report was received for PITC at WRHA for 4 months in 2015.

therefore is underreported. The available date shows that 75% (38,240) of patients were reportedly served with first line regimes, 25% (12,169) on second line and less than 1% on third line. The submission of monthly ARV usage reports from pharmacies continues to be a challenge and adversely affects the HSTU's ability to forecast.

Laboratory Monitoring

A number of laboratory tests are important for the initial evaluation of HIV-infected patients upon entry into care, as well as before and after the initiation or modification of antiretroviral therapy (ART). These tests are done to assess the virologic and immunologic efficacy of ART and to monitor for laboratory abnormalities that may be associated with antiretroviral (ARV) drugs. Two tests are routinely used to monitor HIV-infected patients: CD4 T lymphocyte cell count to assess immune function and plasma HIV RNA (viral load) to assess level of HIV viremia.

Viral load is a marker of response to ART. A patient's pre-ART viral load level and the magnitude of viral load decline after initiation of ART; these results therefore provide information about the probability of disease progression. The key goal of ART is to achieve and maintain durable viral suppression. Thus, the most important use of the viral load is to monitor the effectiveness of therapy after initiation of ART.

Measurement of CD4 count is particularly useful before the initiation of ART. The CD4 cell count provides information on the overall immune function of an HIV-infected patient. The measurement is critical in establishing thresholds for the initiation and discontinuation of opportunistic infection (OI) prophylaxis and in assessing the urgency to initiate ART.

ART is now recommended for all HIV-infected patients. As Jamaica seeks to reach the 90-90-90 treatment targets by 2020, a key component will be the National Laboratory's ability to provide accurate results in a timely manner to ensure quality management of PLHIV patients and to improve the outcomes at each stage of the treatment cascade.

Table 3: Monitoring tests over the period of 2014 to 2016

Year	PCR			CD4			VIRAL LOAD		
	2014	2015	2016	2014	2015	2016	2014	2015	2016
Received	1,045	978	1,124	13,038	14,627	14,227	11,490	15,097	17,743
Processed	891	912	1,070	12,598	14,053	13,749	10,097	14,775	17,331
Positive	6	11	15						
Rejected	76	66	56	440	574	478	506	322	412
Rejection Rate %	7.3	6.7	4.9	3.4	3.9	3.4	4.4	2.1	2.3

CD4 Testing

The results of the CD4 and viral load testing are indicators of the level of immune system impairment. Therefore, they are used to monitor the stage of HIV in PHLIV. Upon linkage to care, all diagnosed persons should receive an initial test to determine their CD4 count. As per national guidelines, they should be tested two times per year thereafter.

In 2016, 14,227 CD4 tests were processed, a 3% decrease when compared with the 2015 figure. In 2016, there was a reduction in the rejection rates of the CD4 samples when compared with 2015. This change is likely the result of the quality assurance efforts of the National Public Health Laboratory and the distribution of job aids specific to the requirements for conducting monitoring tests.

Nonetheless, the malfunctioning of the FACS Calibur machine at the National Public Health Lab disrupted the processing of the CD4 samples.

During the third quarter of 2016, the operations at the lab at the Cornwall Regional Hospital were significantly disrupted due to environmental issues affecting the facility. The lab was subsequently closed. With the closure of the lab, point of care machines were solely in use, however, the throughputs were insufficient to serve the patient load of the facility. In the interim, the FACS Count machine from the SRHA was reassigned to CRH temporarily until access to the main lab was made available.

Viral Load Testing

National guidelines dictate that viral load testing ought to be done six months after starting ARVs and thereafter conducted twice annually. Between 2014 and 2016, there were improvements in viral load testing in Jamaica. In 2016 for example, there was an increase in viral load testing by 18% when compared with 2015.

With the recent acquisition of a Cobas Taqman 96 machine on a lease agreement from Roche; viral load testing is now fully automated from sample preparation through to analysis. The procurement of the equipment has yielded the following results:

- Reduction in the NPHL's internal turnaround time to process samples from over two weeks to as low as 8 days.
- Increased viral load testing throughput to approximately 60-80 tests per day.

Nonetheless, the full capacity of the machine is yet to be utilized, considering that the Taqman 96 machine's full capacity is 192 viral load test/8 hours and 384 test/24 hours. The limitations are largely due to the inadequate physical infrastructure of the NPHL. This has been brought to the attention of the director of laboratory services at the NPHL for its internal action.

The HSTU, in collaboration with the CDC/NPHL is in the process of merging the NPHL's lab information system with the HIV treatment database in order to: 1) facilitate real time reporting and, 2) reduce the time for getting results back to the peripheral sites. This move is in keeping with the recommendations of the May 2016 PAHO/CDC review of viral load testing services.

The streamlining of the procurement process has led to a decrease in stock out of viral load reagents and supplies in 2016 compared with the previous year, as the HST Unit strives to provide optimal treatment care and support services to persons living with HIV. With the

anticipated increase in testing, buffer stocks have been increased to five months to reduce the risks of a stock out.

With regards to the sustainability of viral load testing, there has been a reduction in the price of viral load reagent and a waiver on fees for other viral load testing supplies through continued collaboration with Roche Diagnostics and advocacy through global partners.

DNA PCR Testing

In 2016, 15% more DNA PCR testing was conducted than in 2015. The HSTU recorded higher rejection rates for DNA PCR testing samples in 2016 when compared with the previous year.

PIMA

In 2016, eight government treatment sites received their certification to conduct point of care CD4 testing using PIMA machines. The sites are:

1. St. Ann's Bay Hospital
2. Port Antonio Health Centre
3. Morant Bay Health Centre
4. Falmouth Hospital
5. Savanna La Mar Public General Hospital
6. Mandeville Regional Hospital and,
7. The Department of Correctional Services.

Additionally, PIMA machines have been placed at all three JASL sites, which have all acquired certification for its use.

All certified sites are currently processing samples, with intermittent disruption due to equipment malfunction. The machines are no longer under warranty; however, the HSTU is negotiating service contracts for them.

FACS Presto Machines

During the reporting year, four sites received certification to conduct point of care CD4 testing using FACS Presto machines. The sites are:

1. Port Maria Health Centre
2. Spanish Town Hospital
3. Bustamante Hospital for Children and,
4. May Pen Hospital.

While CHARES was selected as a suitable site, the relevant officers at the site did not meet the criteria for certification. The NPHL will arrange for another training to be conducted at the site.

A stock out of reagents in 2016 disrupted viral load testing and uptake. This was mainly due to an extended clearance time, which was later addressed with the establishment of a memorandum of understanding between the HSTU and the National Health Fund. Another measure that was put in place to avert a stock out of lab reagents was to increase buffer

stocks from three months to five months.

SUPPORT

The HSTU provides support for PLHIV through the HIV management team. The team comprises of Adherence Counsellors, Social Workers, Psychologists and Case Managers. This cadre of workers provides PLHIV with counselling support, psychosocial support and mental health assessments. Their work also entails assisting PLHIV with addressing the social and emotional barriers to accessing HIV treatment care and support services.

In 2016, the HSTU's efforts engage with PLHIV showed positive signs. At one site for example, the Social Worker (SW) noted that there were definite signs of improvement in adherence to ART "[…] since persons joined the support group". In another site, during the same month, the Social Worker explained that, "It is noteworthy that there has been growth among members of the support group in that they support each other by encouraging compliance to medication. There has been improvement in CD4 and Viral Loads of some members."

During the reporting year, the Social Workers engaged with an average of 1,100 PLHIV each month. They provided social investigations for between 80% and 95% of this caseload. The clients' recurring social problems are primarily: 1) lack of the financial means to attend clinic, 2) inadequate food supply and 3) challenges with children, particularly with respect to providing school supplies and ensuring that they maintain their attendance at school. In terms of the work that is to be done with the population, the HSTU notes the significant role that Food for the Poor plays in assisting the HSTU's social support interventions, especially those that meet the nutritional needs of PLHIV.

Towards the end of 2016, it was observed that there was a fall-off in the assessment of adherence with a significant decline in the use of the "pill-count" method. Adherence Counsellors reported that clients were not bringing pills to clinic hence the reduced use of this method. Efforts were made to scale up adherence assessment overall, with focus on pill-count.

The work of the Treatment and Support staff continue to be stymied by the lack of adequate physical resources.

In the latter part of 2016, all categories of staff benefitted from sensitization sessions in treatment literacy and preparedness. The sensitization efforts are expected to continue into the first quarter of 2017 in order to prepare for the introduction of test and treat in January 2017. The test and treat programme is aimed at ensuring that all persons tested HIV+ are offered ART as soon as possible after diagnosis. As part of the programme, instruments to aid in the diagnosis of clients and tools to assess readiness for starting ARV, will be acquired and developed respectively.

Quality Improvement Programme

The Caribbean Regional Quality Improvement Collaborative (CaReQIC 2.0) has achieved significant success at the treatment sites. In 2016, quality Improvement activities were conducted at both PEPFAR and NON-PEPFAR sites. As shown in Table 4 below, there was an overall doubling of viral load uptake from 13% to 27%.

Viral Load suppression in the last 6 months for all patients on ART, though low, also doubled (10% – 18%).

Table 4: Viral load uptake and suppression through quality improvement activities

Sites	VL Uptake		VL Suppression	
	At the beginning	At the end	At the beginning	At the end
1. Black River	9%	28%	2%	22%
2. Comprehensive	11%	26%	8%	24%
3. KPH	11%	44%	6%	20%
4. Linstead	19%	20%	9%	20%
5. Mandeville HC	0%	31%	0%	11%
6. Mandeville Hospital	0%		0%	20%
7. May Pen	13%	40%	8%	26%
8. MoBay Type V	28%	24%	21%	18%
9. Morant Bay	No data	12%	No Data	8%
10. Port Antonio	13%	31%	12%	23%
11. Port Maria	12%	26%	10%	22%
12. St. Jago	12%	34%	7%	23%
13. Windward Rd	25%	32%	16%	19%
Total	13%	27%	9%	20%

The Linstead Health Centre had significant improvement with their lost to follow up (LFTU) effort through the roll out of their Plan Do Study Act (PDSA) cycles and had viral load suppression as high as 55 % in June 2016. Other sites worked on improving the health literacy of patients to improve adherence.

Based on their own experiences with the effect that data quality had on their LTFU percentages, the sites have improved their data quality significantly. During the reporting period, all sites undertook data cleaning exercises, for example by removing duplicate information of patients who had died and patients who had migrated to other sites. The data cleaning exercise yielded significant results for some sites. At the Port Antonio Health Centre, for example, the LTFU declined from 80% to 55%.

ELIMINATION OF MOTHER-TO-CHILD TRANSMISSION (EMTCT) OF HIV

The eMTCT programme is comprised of a cascade of services that include:

a. Provider-initiated testing and counselling at antenatal clinics (ANC) and labour wards,

b. Provision of antiretroviral drugs and/or benzathine penicillin to HIV – positive and syphilis reactive pregnant women and their infants,

c. Delivery at a health facility and,

d. Infant HIV testing and long term HIV care.

The nurses who were initially part of the Research team from JaPPAIDS, continue to lead in the collection of high quality routine data on these services and outcomes for the HIV/ syphilis positive mothers and infants. These nurses were integrated into the Regional Health Authorities. The data they collect is critical as it allows for the monitoring and evaluation of the PMTCT programmes against national and international targets. Additionally, it allows for improved clinical management and follow-up of patients.

The MTCT has continued to decline over the past 3 years (2014-2016) with 2% of babies being infected with HIV in 2014 and 1% in 2016. The rate of congenital syphilis has also declined over the same time period. While significant progress has been made towards achieving the targets set, there is a lag in the achievement of the targets outlined for the key monitoring indicators. Due to this gap, Jamaica is yet to achieve the targets required for elimination status.

Despite the efforts made by the eMTCT Oversight Committee to secure Jamaica's achievement of elimination there are gaps that must be identified and addressed across the health regions. The institutionalization of this programme, the utilization of the regional data collection and national monitoring and evaluation framework, will improve the quality and completeness of data being presented and the level of adherence by healthcare staff to existing protocols.

Table 5: eMTCT validation indicators for Jamaica 2013-2016

Impact indicators	Target	2013			2014			2015			2016		
		Result	Num	Den	Result	Num	Den	Result	Num	Den	Result	Num	Den
HIV MTCT rate	<2%	4%	14	357	2%	8	374	1%	5	345	1%	5	429
Annual rate of new inf. per 1000 infections	<0.3	.35	14	39,500	.23	8	34,978	.13	5	37,556	.139	5	35959
Annual rate of CS per 1000 live births	<0.5	.63	25	39,500	.77	27	34,978	.08	3	37,556	.22	8	35959
Key monitoring indicators													
ANC coverage (at least 1 visit)	>95%	69%	27394	39500	68%	26807	34978	78%	29406	37556	78%	27912	35959
HIV testing coverage of pregnant women	>95%	90%	35479	39500	106%	37040	34978	89%	33552	37556	105%	37623	35959
Syphilis testing coverage of pregnant women	>95%	62%	24452	39500	66%	23020	34978	87%	32673	37556	90%	22166	24640
ART coverage	>95%	91%	407	449	93%	404	436	90%	414	460	95%	408	429
Syphilis Rx coverage	>95%	65%	274	425	715	290	411	23%	129	554	20%	83	406

The preliminary estimate of the number of live births is used as a proxy to determine the number of pregnant women.

Source of data regarding the number of women tested for syphilis: MCSR

Source of data regarding ART coverage and treatment coverage of syphilis: JaPPAIDS

The HSTU intends to conduct an assessment of the PMTCT programme in each parish in 2017, to identify gaps and challenges delaying the institutionalization of this programme across the regions into the family health programme. The HSTU will use information from the assessment to inform the revision of the elimination guidelines.

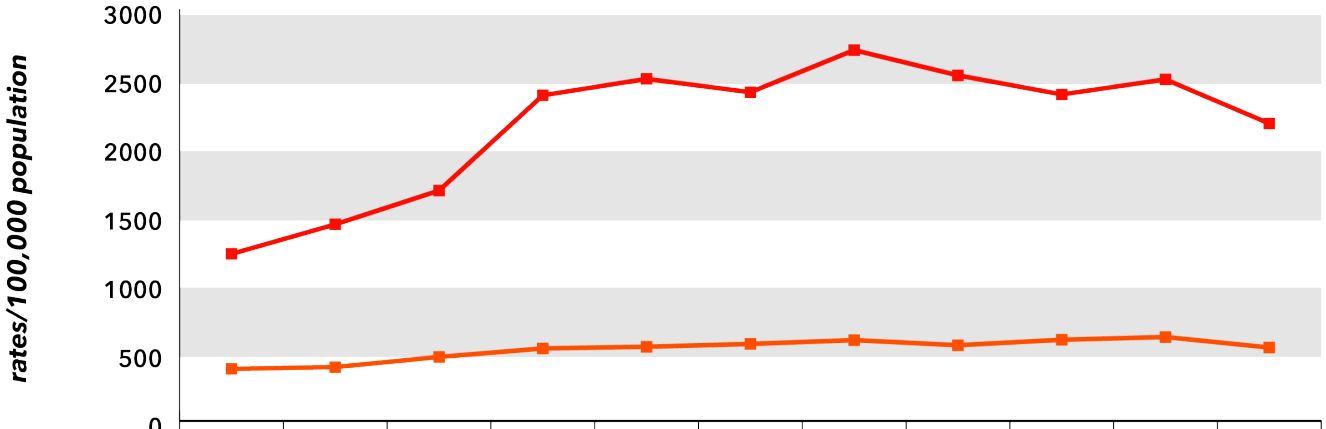
In order to capture obstetric patients that deliver privately, the unit collects and collates monthly pMTCT reports from all private hospitals offering obstetrics services across the island. These include the University Hospital of the West Indies, Nuttall Memorial Hospital, Andrews Memorial Hospital, Hargreaves Memorial Hospital, Royale Medical Centre and Montego Bay Hospital and Urology Centre.

At the end of 2016, 2,200 women were tested in the private sector for HIV and Syphilis during pregnancy with 14 (0.6%) being positive. There were no reported reactive cases of Syphilis. The exposed infants of these positive mothers have all been linked to care and are being closely monitored. Over 37,000 HIV tests were conducted in the ANC in the public setting for 2016 with approximately 1% of test result being positive.

SEXUALLY TRANSMITTED INFECTIONS (STI)

The data collected from STI clinic attendees has shown that most STI clinic attendees are diagnosed with Genital Discharge Syndrome (GDS). Figure 10 illustrates that the GDS rates for 2006 to 2012 were trending upwards, with fluctuations seen thereafter. Similarly, for the years 2006 to 2010, GDS rates were trending upwards in females with fluctuations seen thereafter.

Figure 10: Genital Discharge Syndrome Rates by Sex, 2006-2016

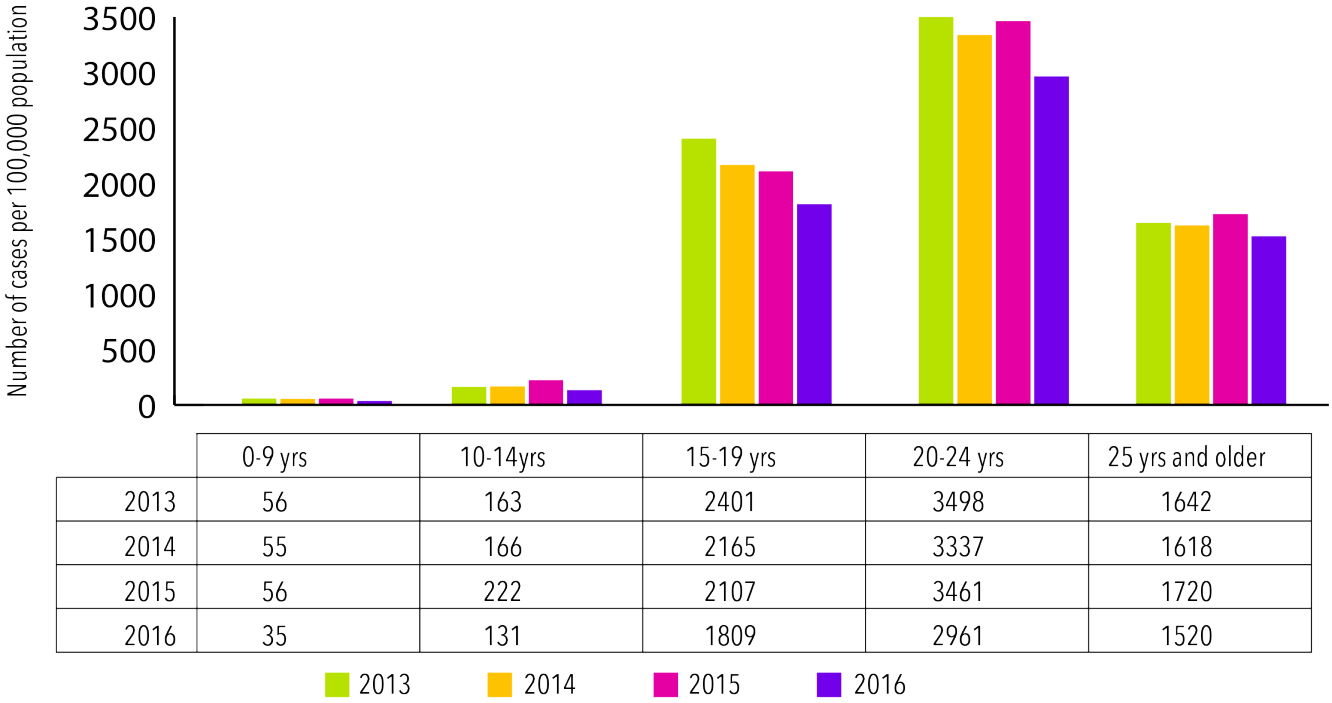


	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Female	1216.6	1432.2	1678.7	2372.6	2429.2	2395	2702.3	2518.1	2378.9	2488.6	2167.4
Male	379	392.5	465.8	528.2	540.2	561	588.7	551.5	591.4	611.2	534.7

Women are three to fives times more likely to be infected with GDS compared to males. The disparity may be attributable to the differences in health seeking behaviours between men and women and the increased susceptibility of women contracting STIs than men.

GDS were most frequently reported by persons aged 20-24 years, followed by those in the 15-19 years age group. Children aged 0-9 years old were also infected with GDS.

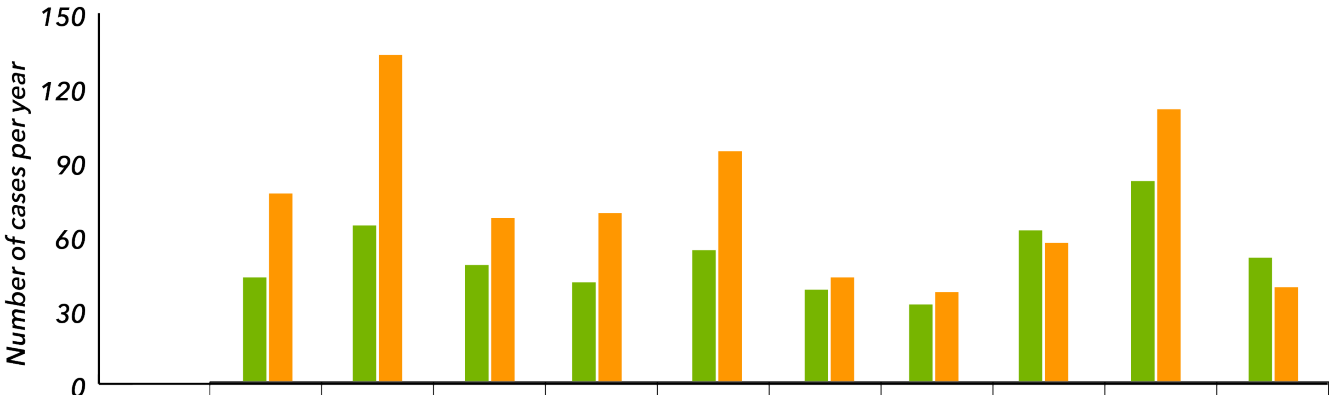
Figure 11: Age-specific genital discharge syndrome rates/100,000 population, 2013-2016



	0-9 yrs	10-14yrs	15-19 yrs	20-24 yrs	25 yrs and older
2013	56	163	2401	3498	1642
2014	55	166	2165	3337	1618
2015	56	222	2107	3461	1720
2016	35	131	1809	2961	1520

Note: Total population from STATIN 2013 demographic report was used as denominator for calculation of rates 2016

Figure 12: Syphilis Reported Cases by Sex, 2007-2016



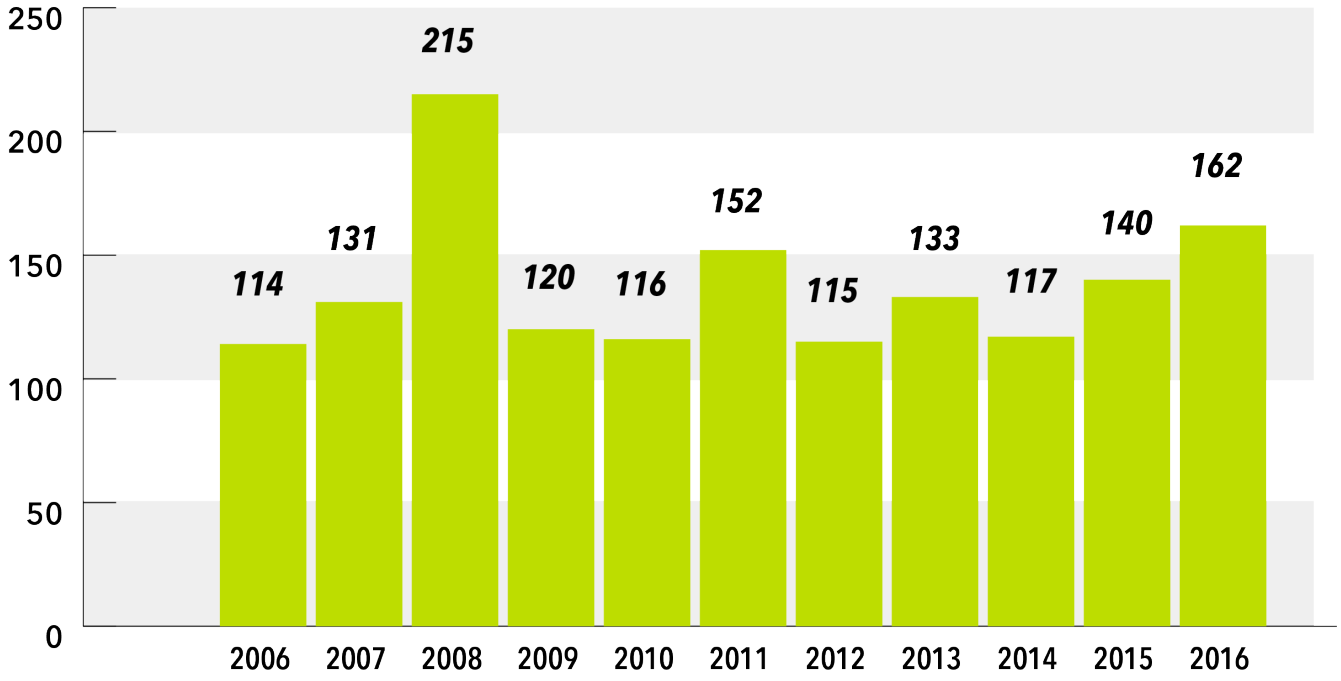
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Male	42	63	47	40	53	37	31	61	81	50
Female	76	132	66	68	93	42	36	56	110	38

The number reported syphilis cases fluctuated over the ten-year period, 2007 to 2016. The highest number of cases was recorded in 2008 and 2015 with 195 and 191 cases respectively. The lowest number of cases (67 cases) was reported in 2013.

Over the same ten-year period (2007 to 2016), women accounted for a greater number of syphilis cases when compared with men, except in the years 2014 and 2016.

As Figure 13 shows, the number of primary and secondary cases of Syphilis fluctuated for eleven-year period, 2006 to 2016. The lowest number was recorded at the beginning of the period under review, 2016, with 114 cases, while highest number of cases was seen in 2008, 215 cases.

Figure 13: Reported number of primary and secondary syphilis cases, 2006-2016



STI Sentinel Survey

As at the time of this report the TCS team was experiencing technical issues in preparing the results of the sentinel survey. The HSTU will send samples to Sweden for testing, including resistance testing. The preliminary results show no genetic resistance of gonococcus at this point. Syndromic management of STIs continues, while the treatment manual awaits revision. The HSTU will use the results of the 2015 surveillance to inform the revision of the manual.

The results from the Microbiology Unit at the NPHL, for swabs from patients with genital discharge syndrome show that the majority of women were positive for yeast +/- bacterial vaginosis, and to a much lesser extent gonorrhoea.

Upon completion of the surveillance study, the treatment manual will be updated to reflect the current STI trends. Additionally, clinical staff will receive training in the management of STIs, as per the revised guidelines.

Tuberculosis

Table 6: Tuberculosis cases in Jamaica, 2012-2016

Cases	2012	2013	2014	2015	2016 (WRHA)
Number of Tb cases detected	95	104	86	147	23
Number screened for HIV	72	95	79	87	24
% of Tb cases screened for HIV	76	92	92	59	100%
Of cases screened, # co-infected	16	16	19	27	1
% of cases co-infected	22	16.8	22	18	4%

For the 2016 reporting period, only the WRHA submitted data on number of Tb cases for 2016. The management of the national Tb programme falls under the responsibility of the HIV/STI/Tb Unit, the strategic plan for which ended in December 2016. Due to a lack of adequate staff in the Unit and in the Surveillance unit, the implementation of many programmes were delayed.

In 2016, CAREC facilitated the use of the Gene Xpert technology for the culture of mycobacterium. In 2016, 65 cases of MTB were detected using the CAREC Gene Xpert, with no resistance detected. No smear microscopy was done at the NPHL in 2016. Smear microscopy has begun on a small scale at the NPHL until the recertification of the bio-safety cabinet is completed. An assessment of the Regional Laboratories has indicated that St. Ann and St. James have cabinets that can facilitate the starting of sputum microscopy once the recertification is done. Manchester on the other hand, needs a cabinet. The staff will also require the appropriate training and technical assistance is being sought from PAHO. The updating of the treatment manual requires review of the paediatric chapter for completion.

CAPACITY BUILDING

The capacity of the psychosocial support team to deliver services expanded considerably during the period under review with the addition of new categories of team members and the hiring of new staff members to existing roles. In 2016, Psychosocial Support Coordinators (PC), who will serve as focal points at the national level, joined the team. Case Manager (CM) is a new category of support staff known that was introduced in 2016. The team benefited from marginal increases in the members of the existing categories of the psychosocial support team namely – Psychologists, Social Workers (SW), and Adherence Counsellors (AC). The

marginal increases in these three categories were offset by normal rates of attrition.

An assessment of the team's capacity to function revealed several gaps. One of the key areas for improvement is the level of communication between and across job categories. During the reporting period, quarterly meetings of the different groups of officers was reintroduced in a bid to close the communication gap. The team also initiated workshops to share best practices geared at building their capacities to better service PLHIV.

Another gap that was identified was the need for training. All categories of staff of the psychosocial support team benefited from training programmes, with emphasis placed on "Treatment Readiness/Treatment Literacy" in preparation for the adoption of the WHO September 2015 guidelines – Treat All. Through this initiative, over 150 persons, representing nine categories of staff received training. Additionally during the reporting period, work began on preparing the formal training of CM and AC. The curriculum for the CM and protocol for the AC were being developed at the time of this report.

With support from USAID 10 Contact Investigators (CIs) will receive training in 2017, so as to address the gap in linkage to care. Preparatory work for the training began in the current reporting period. The field manual and curriculum were reviewed and the technical working group is set to review the CI organizational structure in order to present a sustainability plan for the CI programme.

THE WAY FORWARD

With the adoption of the WHO 2015 guidelines, Jamaica will adopt a 'Test and Treat' protocol in January 2017. All patients, once assessed to be treatment ready, will be offered antiretroviral treatment, regardless of the CD 4 levels. Early initiation of treatment, studies have shown, yields better outcomes and a reduced risk of transmission (treatment as prevention). Preparation for the introduction of this programme includes:

1. Increased efforts to sensitize of all categories of staff
2. Revision of clinical guidelines to include the new strategy
3. Completion of clinical guidelines for the management of Tb and STIs
4. Development of assessment tools for staff to use to determine the readiness of patients to start treatment.
5. Delivery of adherence training in 2017 (upon completion of the adherence protocol)
6. Delivery of case management training for psychosocial support staff

The National Programme is keen on addressing the issue of stock outs for antiretroviral therapy. The NHP therefore intends to request technical assistance support from external partners to strengthen its efforts to improve the supply chain management for antiretroviral therapy in specific areas such as quantification methods, inventory management and quality assurance.

In terms of access to treatment, the NHP anticipates an increase in the number of treatment sites for 2017; new sites are scheduled to open in the Western region while other regions are exploring the possibility of establishing satellite sites. The NHP also anticipates an increase in the number of private pharmacies dispensing ARVs given the number of pharmacies that

expressed an interest in joining the programme.

The CDC will provide technical support to the NHP's effort to electronically link regional labs to NHPHL to enable real time transfer of results for monitoring of patients on ARVs.

The NHP introduced a new web based data collection platform, the DHIS II in 2016.The NHP anticipates that the DHIS II will improve the quality of the data being reported. One of the major features of the linked database is that it team members will be able to track clients who access services across various sites. Therefore it is anticipated that this will reduce the number clients who are lost to follow up.

The care of the adolescent population is a priority going forward as the number of cases recognized in that age group continues to increase. Other key population groups will receive special attention as a framework for the care of key populations is developed with the assistance of Linkages.

The integration of sexual and reproductive health services will be introduced at treatment sites to improve linkage and facilitate better treatment services at all sites.

CHAPTER 4: ENABLING ENVIRONMENT & HUMAN RIGHTS

OVERVIEW

An unfavourable legislative and policy environment in Jamaica contributes to the exclusion and marginalization of key populations, including persons living with HIV. Constitutional rights, as laid out in the Charter of Fundamental Rights and Freedoms, for example, do not list health status as an area that should carry protection against discrimination. The work of the National Family Planning Board's Enabling Environment and Human Rights Unit therefore, is a critical component of Jamaica's programming for HIV/AIDS, STIs and Sexual and Reproductive Health (SRH).

During 2016, the Unit focused its efforts on reviewing laws, policies and practices and facilitating multisector dialogue amongst policymakers, government leaders and stakeholders from diverse population groups. This work lays the foundation for improving access to healthcare services for all.

Devon Gabourel, Director of Enabling Environment and Human Rights, discusses barriers that prevent equitable access to better sexual and reproductive health services and information for all persons in Jamaica.

KEY ACHIEVEMENTS OF THE EEHR UNIT

National Public Consultations for Revision of HIV/AIDS Policy

On May 13, 2015, the Human Resources Committee recommended that the National HIV/AIDS Policy be revised. This task was incorporated into the NISP 2014-2019 as one of its key outputs. The revised policy will strengthen the policy and legal framework for sexual and reproductive health and HIV prevention, treatment and care services. The Unit set out to revise the policy using evidence from strong island-wide stakeholder consultations.

Community consultation in May Pen, Clarendon

The NFPB collaborated with the Social Development Commission (SDC) to organize the public consultations for the revision of the policy. Between May 10 and June 2, 2016, the Unit held 13 consultations across the island, with one consultation being held jointly for Kingston and St. Andrew. The consultations gave the citizens of Jamaica the opportunity to contribute to: 1) the revision of the HIV/AIDS Policy 2) the formulation of The National Family Boards' policy on Sexual and Reproductive Health. A total of 793 persons participated in the consultations.

Table 7: Participation by parish: hiv policy public consultations

Parish	Female	Male	Youth	Total
Portland	19	16	4	35
Manchester	31	12	9	43
Clarendon	17	35	9	52
Trelawny	40	24	12	64
Hanover	38	21	14	59
St. James	36	9	2	45
Westmoreland	38	11	16	49
Kingston/St. Andrew	88	31	-	119
St Mary	21	21	17	42
St. Thomas	50	21	20	71
St. Catherine	46	15	13	61
St. Ann	48	19	3	67
St. Elizabeth	55	31	35	86
TOTAL	527	266	154	793

The participants, who were mobilized with help from the Community Development Committees, represented 257 communities island-wide as well as various government institutions, non-government organizations (NGOs), community based organizations (CBOs) schools and churches.

The specific priority areas were validated by a majority of the participants. The priorities are: Prevention of HIV infections; Treatment, Care and Support; Enabling Environment & Human Rights; Mitigating the Impacts of HIV; and Strengthening Community Systems for Responding to HIV.

In most parishes, the participants' feedback with respect to programme priorities is that there is a need to:

1. Sensitize healthcare workers to avoid discrimination against minors
2. Make laws to allow access to preventative measures and a treatment for persons under 18 but not below 14

3. Strengthen the complaints reporting systems to include minor complainants.
4. Promote abstinence, and faithfulness and contraception: let the people decide
5. Promote visits by medical personnel in schools
6. Give children between aged 10 years to 25 access to age-appropriate HIV related information
7. Have in place employment laws to protect infected and affected persons

It was noted that stigma and discrimination was a major barrier for PLHIV. Rumours surrounding PLHIV and services that are offered at the different health facilities must be dispelled, for example, one person pointed out that HIV medication was given to patients in a brown paper bag.[2] It was noted that PLHIV were often discriminated against which may be due to a lack of education and while PLHIV have access to treatment and care it is not accessible to all based on socio-economic standings. It was also noted that there is no anti-discriminatory law to protect PLHIV.

Through the consultations the Unit found that most persons are aware of the drivers of the epidemic such as multiple partnerships, lack of condom use and transactional sex, particularly among the youth. In terms of the participants' perceptions on the barriers to ending the epidemic, most persons theorised that the lack of information about HIV and AIDS is a more significant barrier than the existence of practices and policies that promulgate HIV-related prejudice, bias, stigma and discrimination. It was stressed that there should be sensitivity to person's privacy and status in health care facilities.[t]

Participants in public consultations when asked what they believed were the main sexual and reproductive health issues which needed to be addressed in policies and programmes designed by the Government, indicated that the age of consent was paramount while abortion and HIV and disease prevention were also of great import. See table below.

[2]*Public Consultation in Clarendon*

[3]*Ibid*

Table 8: Main SRH issue to be addressed by the Jamaican Government

Responses	Frequency	Percentage
Better Health Facilities	6	5.6%
Abortion	17	15.7%
Age of Consent	24	22.2%
Buggery & Homosexuality	6	5.6%
Confidentiality on the part of health workers	2	1.9%
HIV and Disease prevention	19	17.6%
Pregnancy due to rape	11	10.2%
Incest	4	3.7%
Sex with minors	2	1.9%
Sexual education	12	11.1%
Stigma and discrimination	5	4.6%
Total	108	100%

THE GREATER INVOLVEMENT OF PERSONS LIVING WITH HIV AND AIDS (GIPA)

In 2016, the Unit continued its efforts to operationalize a global principle that aims at realizing the rights and responsibilities of people living with HIV, including their right to self-determination and participation in decision-making processes that affect their lives. In the Jamaican context, this is done through "The Capacity Building Project for The Greater Involvement of Persons Living with HIV and AIDS (GIPA)".

For the period under review, the GIPA Coordinator worked to establish partnerships with the RHAs through the initiative, Community System Strengthening (CSS). Through the partnership, adherence counsellors and PWHIV community leaders benefited from GIPA Capacity Building Workshops. The Project delivered the workshop using the Positive Health Dignity and Prevention (PHDP) Curriculum. Additionally, the GIPA Coordinator engaged with RHA policy decision makers on the CSS and shared the Project's recommendations to build community engagement mechanisms.

The NFPB provided support for the deployment of eight GIPA-trained Community Facilitators (CF). Two of the eight CFs were assigned to the NFPB and were deployed to the Southern Regional Authority (SRHA). The CFs supported the GIPA Unit's interventions in the region by mobilizing target groups for future cohorts for GIPA capacity building initiatives and provided input on the delivery of services to PLHIV of key populations.

Delivering PHDP Curriculum to PLHIV leaders and treatment adherence councillors

Two of the CFs also participated in existing training workshops targeting Peer Navigators, and Prevention/BCC team members in all four RHAs through collaboration between NFPB and Linkages (PEPFAR/USAID). The CFs delivered presentations on aspect of the PHDP modules on Dealing with Disclosure, Treatment Literacy, and PHDP Overview. Both the GIPA Coordinator and CFs supported the revision and customisation of the PHDP Curriculum and responded to invitations to support initiatives of the NFPB, RHA, HST Unit of the Ministry of Health and JN+.

The CFs supported the GIPA Unit's interventions in the region by mobilizing target groups for future GIPA training cohorts and provided input on the delivery of services to PLHIV key populations. The GIPA Unit monitored and mentored the CFs.

GIPA Capacity Building Project Facilitators preparing for a session with PLHIV peer leaders

NATIONAL FRAMEWORK TO REDUCE STIGMA AND DISCRIMINATION

The Enabling Environment and Human Rights Technical Working Group (EEHRTWG)

The Enabling Environment and Human Rights Technical Working Group (EEHRTWG) was established in January 2014 as an independent advisory body of partners, policy experts and key thinkers in sexual reproductive health and human rights issues. The working group provides guidance to the national sexual health response on human rights violations and stigma and discrimination.

In 2017, the EEHRTWG reviewed the existing stigma and discrimination (S&D) training material that is used to build capacity of health care workers to determine the gaps in the material. Stakeholder groups representing MDAs (including RHAs), CSOs NGOs and IDPs participated in the review process.

National Stigma and Discrimination Consultations

In order to advance the national dialogue on stigma and discrimination, EEHR Unit hosted a series of national consultations between February and June 2016 on the importance, and relevance of the draft regulation/Code of practice on confidentiality and the protection of health records. Representatives from all the health regions and persons from key and vulnerable populations, such as youth, PLHIV, MSM and FSWs attended.

Confidentiality Policy community stakeholder consultations

Redress Framework

The objective of the comprehensive redress framework is to make available to all Jamaicans and particularly, key population groups, recourse for undesirable or unfair treatment arising from any form of discrimination, such as on the basis of health status, sexual orientation and gender identity.

During the reporting period, the EEHR Unit solicited stakeholder feedback on the development of a comprehensive Redress Framework. The NFPB secured technical assistance from Health Policy Plus (HP+) to bring a Governance Specialist on board to spearhead the consultation with key stakeholders and partners. The focus of the consultations was to: 1) discuss the requirements of a reporting and redress system for PLHIV and KPs and 2) creation of recommendations needed to establish a comprehensive redress framework that would eventually become a mandate of the Office of the Public Defender (OPD).

As per recommendations outlined in a May 2013 report titled, "A Review of the National HIV-Related Discrimination Reporting and Redress System in Jamaica" the following goals are being pursued until 2018:

a. Development and implementation of a common protocol for the identification of discrimination by redress entities

b. Development of a common reporting tool for redress entities

c. Establishment of a proper data collection system for data collection, storage, retrieval and analysis, and generation of reports and trends of stigma and discrimination

d. Circulation of the User Manual for the Administration of Discipline in Executive Agencies

CAPACITY DEVELOPMENT ACTIVITIES

During the reporting period, the EEHR Unit partnered with the Jamaica Employers Federation, CSOs, PLHIV and representatives from key population groups to deliver skills-building workshops. Twenty representatives from key population groups and PLHIV benefited from a six-day training workshop aimed at strengthening their employability skills.

Fifteen staff from five CSOs[4] were trained in human resource and project management skills during a three-day workshop session. Other CSOs received support to assess HR systems with the view to make recommendations on how to improve, particularly in areas such as developing their HR policies and manuals. Other CSOs also benefited from support to develop effective project management systems. Other activities included sensitization sessions at public sector entities.

[4] *SWAJ, JN+, JASL, ASHE and JCW+*

CHAPTER 5: ADOLESCENT AND YOUTH HIV RESPONSE

OVERVIEW

The Adolescent and Youth Component of the National HIV/STI/Tb Unit is a new addition to the HIV response. The specific focus on adolescents re-emerged in 2015 with the introduction of the All In initiative and the continued partnership between the Ministry of Health and UNICEF. The primary goal of All In is to reduce AIDS related deaths and new HIV infections among adolescents.

The findings from All In was used to leverage further support to programming for HIV prevention, treatment and care among young people. This includes, enhancing the package of care for adolescents living with HIV (ALHIV) through an increased cadre of adolescent psychologists at treatment sites, increased funding for adolescent support group meetings and social support to maintain school attendance as well as retention in care.

The mandate of the Adolescent and Youth component is guided by the All In Youth and

Adolescent Technical Working Group (YATWG) and the Adolescent Policy Working Group (APWG). Below are highlights of some of the major activities carried out in 2016.

All In YATWG quarterly meetings and training

The All In TWG comprises a diverse group of young people including young people living with HIV, in school and out of school youth and youth in other key population groups. The YATWG provides an opportunity for youth participation in the national HIV response. Sexual and reproductive health (SRH) issues that affect young people are explored within the group and opportunities for influencing policy decisions are considered. Building the knowledge and skills of young people around SRH and HIV is critical in ensuring that service is not only accessible but also acceptable.

The group meets quarterly and the membership comprises young people ages 15 to 24 years. They have actively contributed to matters on the public agenda such as the revision of the Sexual Offenses Act - changing the age for sexual consent, access to reproductive health services and commodities for minors and the Health and Family Life Education (HFLE) curriculum of the Ministry of Education. The National Family Planning Board is the secretariat for the group.

Members of the YATWG being trained in Social Media Advocacy

Adolescent Policy Working Group

The APWG represents a collaboration between the Family Health Unit and the HIV/STI/Tb Unit of the Ministry of Health. The group comprises members from Ministries Departments and Agencies such as Health, Education, Social Protection as well as Civil Society and Academia. The major tasks of the group include overseeing the development of the adolescent strategic plan, developing a concept note and cabinet submission on access to SRH services and commodities for minors and implementation of the an adolescent hub "Teen Hub" at the Half Way Tree Transport Centre.

The Teen Hub at Half Way Tree Transport Centre

The Teen Hub provides basic HIV and SRH services such as HIV and Syphilis testing for those 16 years and over, access to condoms, HIV risk reduction counselling, Information on HIV prevention and referral for STI screening. Other services include mental health screening and counselling, homework assistance, career guidance and access to computers and internet.

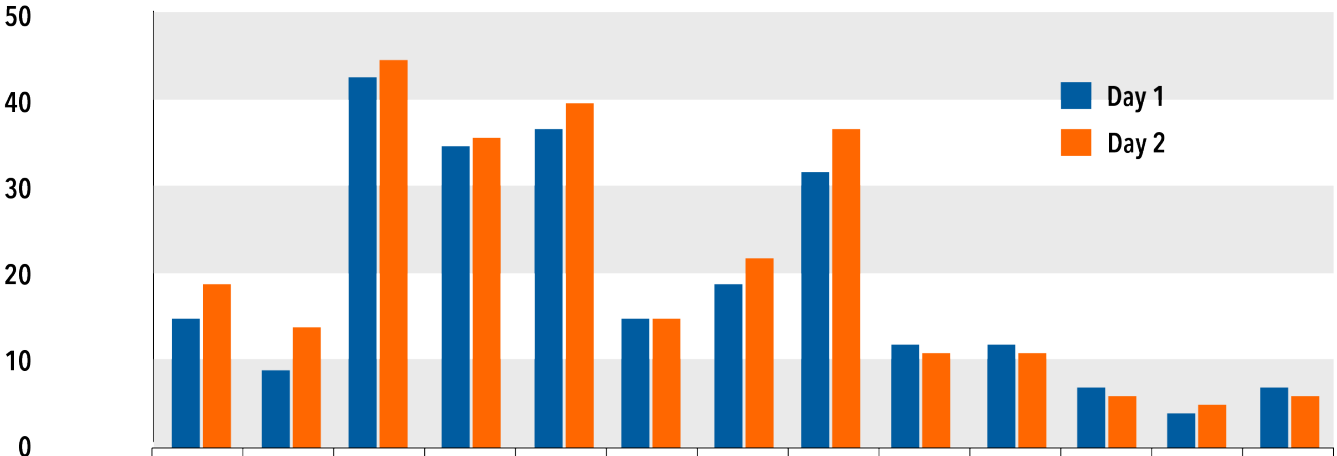
Training of Health Care Workers (HCW) in adolescent standards and criteria

The overall goal of the parish-level workshops was to sensitize health care workers and providers to the adolescent health standards through a process that would ultimately make easier the introduction of the standards into facilities that serve adolescent clients. The expectation was that, at the end of each 2-day workshop, participants would be able to:

- Describe the process adopted by the Ministry of Health to develop the Standards for adolescent health;
- Name the sexual and reproductive health risk factors affecting vulnerable adolescents and those living with HIV.
- Choose and apply effective ways to address challenges that arise when providing health services to adolescents; and
- Utilize the new skills in values clarification and emotional intelligence to provide quality services to adolescents.

Thirteen 2-day parish-level training events were conducted between June 6 and August 18, 2016 and just over 250 HCW were trained from the categories illustrated in the graph below.

Figure 1: Categories of Health Care Professionals represented each day of Adolescent Standard of Care Workshop



	Medical Officer	Mental health	Nursing	Midwifry	CHA	Records	HEO/ BCC	HIV team	Social worker	Orderly	Dental	Nutrition	PNA
Day 1	15	9	43	35	37	15	19	32	12	12	7	4	7
Day 2	19	14	45	36	40	15	22	37	11	11	6	5	6

UNAIDS High Level Meeting (HLM) consultation with adolescents and youth

The United Nations General Assembly High-Level Meeting on HIV and AIDS (HLM) that took place 8-10 June 2016 provided a critical opportunity to further secure political commitment for the actions necessary over the next five years to stem the epidemic by investing in young people. Using the ALL IN platform, the meeting was held through the ALL in Platform with oversight from JYAN with the following objective:

- Generate shared understanding of HIV epidemic priorities, opportunities and challenges of new context on how to accelerate progress towards ending AIDS by 2030
- Discuss and agree on national priorities for young people in order to fast-track the local response by 2020 and end the AIDS epidemic by 2030
- Agree on a position paper to inform the HLM and HIV response work in country

Young people deliberating at the UNAIDS Youth and Adolescents HLM local consultation

At the end of the consultation process, the group decided on four priority areas:

1. Adolescents should be included as a key population
2. Increase access to Comprehensive Sexuality Education (CSE)
3. Strengthen treatment programmes for adolescent to improve adherence
4. Address laws that affect access to SRH services for adolescents

All In stakeholder consultation and planning workshop

This workshop was convened over two and a half days with representation from youth organisations, government and civil society. The specific objectives were to:

- Strengthen partnership between government and civil society groups to improve coordination of adolescent programme implementation among service providers
- Facilitate interactive group activities based on specific thematic areas such as HIV testing, ART, mental-health and substance use to address bottlenecks and gaps in existing systems.
- Develop an operational plan for the implementation of recommendations and key actions identified during the consultative process and group activities.
- Facilitate adolescent and youth participation in planning and decision-making process

Workshop participants were tasked with developing action plans to address previously identified gaps and bottlenecks under three thematic areas: Treatment Care and Support, HIV/STI Prevention and Mental Health and Substance use

Workshop participants huddle in groups to develop action plans

CHAPTER 6: MONITORING & EVALUATION

MAIN ACHIEVEMENTS

A key area of focus in 2016 was the advancement of two web-based databases (using the DHIS2 platform) for HIV treatment and for HIV prevention services; dubbed the Treatment Services Information System (TSIS) and the Prevention Services Information System (PSIS) respectively. Prior to the development of these web-based solutions, the HIV treatment sites had stand-alone databases that were not linked to each other. This made it difficult to track and manage patients that sought care at multiple sites, provide technical support in terms of trouble-shooting and collate data for national analysis and reporting.

The prevention services did not have a standardized database that was used universally by the respective prevention teams. With the implementation of the UIC in 2016, it became critical for a standardized database to be developed. The implementation of these data systems will enable both the HIV treatment sites and prevention services to be able to see a comprehensive history of services received by each client, de-duplicate clients seen across multiple access points in real time, while still being able to update the services provided by their respective agency.

The design of both databases was completed in 2016 with support from the developers of

DHIS2 in Uganda. For the Treatment Services Information System, regional sensitizations were held. Staff with management responsibility and those that will interface directly with the System received training and were given the opportunity to provide feedback on the experience. The feedback was subsequently incorporated.

A similar process was also done for the Prevention Services where a demonstration was done with key stakeholders in the UIC technical Working Group followed by a pilot with actual data from the UIC forms. In addition to the database development, investments were also made in improving the hardware capacity at national and subnational levels to support the hosting of these web-based databases at MoH and the NFPB respectively, as well as the remote connectivity of the sites through secured internet connections. The rollouts of these web-based information systems are being done on a phased basis that will continue in 2017.

Another area of focus in 2016 for the M&E Unit at MoH was the preparation of field staff for the change in national guidelines for HIV management to become more aligned with the WHO 2015 recommendations. M&E team members participated in joint site visits with members from Treatment, Care & Support at parish level meetings. A presentation highlighting the WHO 2015 guidelines to be adopted was shared followed by discussions concerning the measures that needed to be in place in preparation for these changes.

CAPACITY BUILDING FOR MONITORING AND EVALUATION

A CARPHA-led assessment of M&E capacity of staff in treatment sites in 2015 underscored the fact that the extent of M&E function for treatment at sub-national levels focused solely on reporting. There was no dedicated staff with sole responsibilities for M&E function and several persons noted that they did not perceive themselves to be adequately equipped to perform the necessary data analysis to inform their operations at a local level. These findings mirrored those that were brought to the fore in a 2008 assessment.

As such, capacity building through training of treatment site staff continued to be a priority for the M&E Unit at the Ministry of Health. In 2016, both a basic and an advanced M&E skills training workshop were coordinated for treatment sites including middle managers and site coordinators. The Basic M&E Skills Training followed the CARPHA curriculum and emphasized the definitions of monitoring and evaluation, the development and use of logic models, indicators and data quality. The Advanced M&E Skills Training was delivered in partnership with CARPHA but primarily followed the modules developed by MEASURE Evaluation for Data Appreciation and Data Utilization.

There was also opportunity for internal capacity building of M&E members at the Ministry of Health. Although Jamaica has been able to generate treatment cascades for PLHIV over the past few years, one for the key populations (KP) had not been generated. The biostatistician from the M&E Unit (MoH) was thus given the chance to participate in a regional training hosted by CDC that provided support to generate a national KP treatment cascade for the first time.

RESEARCH

Three main research activities were coordinated by the M&E Unit in 2016:

1. The National AIDS Spending Assessment (NASA),
2. A qualitative assessment for key population status capture in clinical settings and,
3. The annual HIV serosurvey among antenatal and STI clients.

The National AIDS Spending Assessment, is an expenditure analysis that follows a standardized methodology put forth by UNAIDS. This is the third time Jamaica has undertaken this analysis, and in keeping with the previous exercises, this assessment covered two financial years: April 2013 – March 2014 and April 2014 – March 2015. It has been repeatedly noted though that the delayed retrieval and analysis of this data is tedious to collect and limits the usability of results. Hence, another NASA initiative is already being planned for the 2015/2016 financial year. This iteration should also include the institutionalization of this specific data capture within routine data reporting frameworks that will facilitate timelier and easier collation of this data; and thus be more useful in supporting evidence-based resource allocations.

The assessment for KP-status capture in clinical settings was a qualitative assessment among both KP members and health care workers using focus group discussions and in-depth interviews. It explored the barriers and enablers to KP members disclosing their KP status in clinical settings; and health care workers' comfort in eliciting this information systematically. The findings will guide the training of providers.

Finally, the HIV sentinel surveillance sero-survey is conducted each year to help determine HIV prevalence rates in the general and at risk populations. HIV tests are routinely offered to both group of clinic attendees but the survey involves additional data capture and submission during the data collection period. A sample size is calculated and proportional quotas based on clinic populations are assigned to each of the six sentinel sites: three urban and three rural. Participants are conveniently selected for inclusion in the survey between the ages of 16 and 49 years until the respective quotas have been met.

STRENGTHS, CHALLENGES AND THE WAY FORWARD

Jamaica NP has a relatively advanced M&E system that is able to collect and analyze data from multiple data sources including planned and budgeted research studies. The system was developed around the 12-component M&E framework proposed by UNAIDS. Operational guidelines for M&E are available and updated periodically; and the culture of routinely using the data to guide programme design exists. The NP's M&E also benefits from strong organizational partnerships with other agencies that support system strengthening for the availability and quality of strategic information to guide decision-making.

Fragmentation of data systems is a challenge, particularly among the data systems for treatment of PLHIV at the clinics, HIV surveillance and testing at the national laboratory. The MoH recognizes that this fragmentation contributes to inefficiencies and missed opportunities to improve availability and quality of data used for patient management and reporting. In 2017, a priority of the Ministry of Health, through support from the CDC, is therefore to develop a solution so that the various data systems can become more connected and integrated.

Underreporting is another major challenge that the M&E Unit at Ministry of Health faces. While it had always been suspected, it has now been confirmed through data triangulation exercises and quantified through the audit of the HIV case-based surveillance system that was conducted in 2016. In partnership with the National Surveillance Unit, the M&E Unit will be focussing on helping the parishes to identify and improve systematic weaknesses that consistently contribute to this gap in data quality which will in turn, strengthen the decisions that these data inform.

Finally, the MoH has long recognized that while important, training in and of itself is insufficient to address the capacity gaps for M&E at a subnational level. Therefore, a key activity for M&E in 2017 will be conducting an assessment for human capacity for M&E, particularly at subnational levels, in collaboration with CARPHA. This will be used to inform a human capacity plan to strengthen the overall M&E capacity.

CHAPTER 7: GRANT MANAGEMENT

OVERVIEW

The Government of Jamaica (GOJ), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) and the United States Agency for International Development (USAID) are the three (3) major funders of the national HIV/AIDS response in Jamaica. The Ministry of Health (MOH) is the Principal Recipient (PR) of the funds and the HIV/STI/Tb Unit within the MoH is the Project Coordinating Unit (PCU) for the national response.

Jamaica receives funds under the GF New Funding Model (NFM) Grant entitled "Support to the national HIV/AIDS response in Jamaica" and through PEPFAR/USAID grant entitled "Threats to the Environment and Citizen Vulnerability Reduced – Prevalence of HIV/AIDS in Key populations reduced".Both GF and PEPFAR/USAID support activities and interventions that target key populations (female sex workers & men who have sex with men) and PLHIV. The GOJ is responsible for targeting general populations as well as key populations and PLHIV.

Funding from all three supports the main components of the HIV and AIDS response:

- Treatment, Care and Support (TCS)
- Prevention
- Enabling Environment and Human Rights (EEHR)
- Monitoring and Evaluation (M&E)
- Governance and Programme Management

GLOBAL FUND

The Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) was established in 2001. Based in Geneva, its governance and management structures comprise the GF Board, the Secretariat and the Technical Review Panel (TRP). Other key structures are the Office of the Inspector General (OIG) and the Partnership Forum, a Local Funding Agent (LFA) contracted to provide independent advice to the GF on programme performance and the Country Coordinating Mechanism (CCM).

The Global Fund Grant Cycle

Under the GF New Funding Model grant cycle there are three major stages;

1. Concept note development and approval
2. Grant making and approval
3. Grant implementation.

Global Fund New Funding Model (NFM) Grant

January 2016 commenced a new performance period based on the Grant Agreement signed with the Global Fund. Under NFM, there were 19 implementing stakeholders – four (4) Sub-recipients, six (6) Sub sub-recipients, three (3) Implementing Partners and six (6) other implementing stakeholders.

Even though the first disbursement from GF was received in January 2016, expenditure in the first quarter was significantly low due to challenges with recruiting the staff who were responsible for implementing the activities. In Year 1, savings were realized due to the reduction in ARV unit cost and HR cost due to late hiring. Also there were savings due to a significant reduction in Viral load reagents unit cost. Some of the savings were reprogrammed to fund the adolescent programme that was approved in October 2016.

Global Fund NFM Program

(Disease) Component:	HIV/AIDS
Program Title:	Support to the national HIV/AIDS response in Jamaica
Grant Name:	JAM-H-MOH
GA Number:	914
Grant Funds:	Up to the amount of US$15,242,178 (Fifteen Million Two Hundred Forty Two Thousand One Hundred and Seventy Eight US Dollars) or its equivalent in other currencies.
Implementation Period:	From 01 January 2016 to 31 December 2018

Goals:

1. Reduce AIDS related morbidity and mortality with effective Biomedical and supporting interventions;
2. Reduce new HIV infections among key populations through behavioural and structural interventions.

Strategies:

1. Prevention: Targeted prevention interventions for key populations primarily through outreach services;
2. Treatment, Care and Support: support procurement of ARVs and improve adherence and availability and quality of counselling and psychosocial support for PLWHA; and
3. Enabling Environment and Human Rights; empowering beneficiaries of HIV national policies to understand their rights and pursuing efforts to reduce stigma and discrimination.

Categories for planned activities

- Scaling up Prevention among Key Populations
- Improved access to treatment, care and support and improvements along the treatment cascade
- Strengthening Community Systems and Removing Legal Barriers
- Health Information Systems and Monitoring and Evaluation

Target Group/Beneficiaries

- Men who have sex with men (MSM)
- Female sex workers (FSW)
- Transgender people (TG)
- People living with HIV (PLWHIV)
- Homeless drug users

- Youth and adolescents, with emphasis on those pertaining to key population

PEPFAR/USAID

The Office of the Global AIDS Coordinator (OGAC), Washington, USA works with the PEPFAR Caribbean Regional Office, the USAID mission in Jamaica, the MOH and other in-country stakeholders in the design of the programme, annual work plans and budgets, as well as monitoring the performance of the HIV/AIDS grant. The Ministry of Health represents the government and is responsible for the management of the grant and ensuring results are achieved.

USAID Grant Cycle

There are five major stages;

1. HIV programme (intervention/activities) development
2. HIV programme approved
3. Detailed work plan & budget development
4. MOH consolidated work plan and budget approved
5. Grant implementation

The Jamaica PEPFAR/USAID Grant

October 2015 commenced a new performance period based on the Grant Agreement signed with USAID. Under this grant, there were twelve (12) Sub-recipients, 10 of which receive support from GF as well.

The lengthy process to finalize the implementation letter (IL), resulted in the Ministry of Health receiving the first disbursement December 2015, which significantly delayed the implementation of activities in the first quarter. It is important to note that the uncertainty which surrounds these lengthy delays greatly affected the implementing entities' ability to effectively plan and complete their activities in a timely manner.

OBJECTIVE 1: To support key population groups (MSM and SW) and PLHIV in accessing the Continuum of Prevention, Care and Treatment (CoPCT) and improve retention in the clinical cascade

OBJECTIVE 2: To reduce stigma and discrimination and improve the protection of the rights of selected vulnerable groups through building the capacity of stakeholders involved in HIV prevention, care, and treatment.

OBJECTIVE 3: To support the capacity of stakeholders (KP, PLHIV, CBO/NGO and government) through use of strategic information to improve programme and policy outcomes.

Description of Major Activities:

Prevention

1. Scale-up targeted prevention outreach interventions serving KP and priority populations which includes but not limited to site and venue-based interventions, HIV counselling and testing (HTC), MSM lyme and linkages to timely treatment, care and support for SW, and MSM as well as referrals other needed social services.

2. Implementation of peer link strategy to reach KPs and increase their access to core package of prevention, care and treatment services.
3. Development and implementation of social media strategy focusing on HTC and treatment.

Enabling Environment and Human Rights (EEHR)

1. Strengthening the documentation of S&D reporting in the redress system at the site level through capacity building sessions with healthcare workers, PLHIV and KP representatives.
2. Development of Human Rights Curriculum and training of key stakeholders from CSOs and government entities in Human Rights and the delivery of service
3. Training of PLHIV and KP community leaders in PHDP
4. Situational analysis of 9 PEPFAR sites and the development of a HCW guide on engaging for KPs

Treatment, Care and Support (TCS)

1. Increasing awareness of case management system/protocol through series of sensitization sessions and quarterly meetings.
2. Build the capacity of outreach staff in conducting Provider Initiative Testing and Counselling (PITC).
3. Scale-up efforts to identify and contact patients to increase number of patients returning to care.
4. Conduct support groups with PLHIV.

Monitoring, Evaluation and Research (MER)

1. Conduct training sessions with treatment site staff in the manipulation of the DHIS2 software for HIV patient management
2. Develop and implement an electronic UIC system
3. Conduct site visits to support staff in the cleaning of the treatment database and conduct one-on-one or small group training sessions.

Overview of the Structure

Funder	Implementation period	Priority Area	Funds Earmarked	Comment
GF	January 2016 – December 2018	All 14 parishes PLHIV, MSM, FSW, TGs	US$15,242,178	Funding agreement signed for 3 years
PEPFAR /USAID	October 2015 – September 2016	Select Parishes and treatment sites PLHIV, MSM, FSW	US$2,600,000	Funding agreement signed for 1 year and based on availability of funds
PEPFAR /USAID	October 2016 – September 2017	Select Parishes and treatment sites PLHIV, MSM, FSW	US$3,105,000	Funding agreement signed for 1 year and based on availability of funds
GOJ	Unlimited	All	J$ as approved in the Estimates of Expenditure (GoJ) Budget	As donor funding decrease, GOJ continuously increases its contribution

CONTRACTS AND AGREEMENTS

The Country representatives signing the agreements under GF are as follows:
GF agreement is signed on behalf of the Government of Jamaica by the MoH and the Ministry of Finance and Public Service (MoF&P) as well as by Jamaica Country Coordinating Mechanism (JCCM) members (the Chair & NGO representatives).
The USAID agreement is signed by the MoH. MoH contracts implementing stakeholders. The grants are performance based hence the amount of funds disbursed to the country is based on its performance in meeting the targets and the indicators. The functions of the entities/structures in the response are described below.

Entity	Description
Ministry of Finance and the Public Service (MoF&P)	• Legal representative to sign and manage loans, credits and grants on behalf of the GoJ and passes the responsibility of management of loans/grants to the MoH. • Annually approves and creates fiscal space to accommodate the HIV/STI/Tb Unit budget • Provides the recurrent GoJ and the GoJ contributions budget complementing the donors' grants • Issues warrants based approved budgetary allocation to support PCU's warrant requests. Warrants are non-cash for grant resources and cash for GoJ resources. • Jointly (with MOH) manages the GF US Currency Special Account • Facilitates transfer of funds from the Bank of Jamaica (BoJ) to the MoH via processing of Withdrawal Applications.
The Ministry of Health (MoH)	• The preeminent government organization whose mandate is "To ensure the provision of quality health services and to promote healthy lifestyles and environmental practices". • Manages health sector donor-funded projects channelled through the GoJ which includes the funds that support the National HIV response programme • Refers to as the Principal Recipient (PR) under the HIV response • Contracts implementing stakeholders under the GF and USAID grants (Implementation Agreement)
The HIV/STI/Tb Unit (PCU)	• Responsible for the National HIV response and is the MoH arm entrusted with the management, coordination and monitoring of HIV donor-funded programmes. • Referred to as the Project Coordinating Unit (PCU) that supports MoH in its capacity as Principal Recipient (PR) of the Global Fund grant resources. • Responsible for providing technical support and guidance in Treatment, Care and Support, Grant Management, Financial Management; Procurement and Supply Management, M&E and HR&Administration • Procures and coordinates the supply and distribution of health products and non-health products which includes ART and test kits for the response • Submits reports/updates to the MoF&P, JCCM, USAID, GF and Planning Institute of Jamaica (PIOJ)

Entity	Description
The National Family Planning Board (NFPB-SHA)	• Responsible for the development of the National Integrated Strategic Plan (NISP) • Responsible for providing technical support, guidance and monitor the implementation of the Prevention, Enabling Environment and Human Rights (EEHR) Components and M&E of the HIV/AIDS response • Provides and coordinates storage and distribution of condoms, lubricants and IEC materials • Receives donor funding from MOH to implement prevention and EEHR interventions/activities • Submits reports/updates to the PCU/PR
The Jamaica Country Coordinating Mechanism (JCCM)	• Multi-sectoral body that has oversight for the GF grant since February 14, 2003 • Comprises representatives from all stakeholders involved in the HIV/AIDS response including: International partners, private sector non-governmental organizations, civil society and the Government • Provides leadership and direction to the GF programmes in Jamaica • Coordinates the development and submission of concept notes to the GF • Nominates the principal recipient and oversees grant implementation, performance and closeout
Implementing Stakeholders (IS)	• Selected through a transparent and competitive process and undergoes annual capacity assessment exercise to determine capacity to directly manage funds and implement interventions/activities • Classified as Class A or Class C entity (defines whether the entity directly or indirectly manages funds) • Contracted to implement designated programmatic interventions/activities under GF and USAID grants • Plays a pivotal role in the implementation of and reporting on programme activities, management of grant resources and the timely achievement of indicators and targets. • Referred to as Sub-Recipients (SRs), Sub Sub-Recipients (SSRs), Implementing Partners (IPs), other implementing entities and government agencies & statutory bodies. • Submits reports/updates to PR/PCU, NFPB-SHA and JCCM

IMPLEMENTING STAKEHOLDERS (IS)

There are a total of 21 implementing stakeholders. Ten (10) of which receive funds from both the PEPFAR/USAID and GF grants.

- GF Grant has four (4) Sub-Recipients (SRs). Three (3) of the SRs manages funds for a total of six (6) Sub-sub-Recipients while the other SR sub-contracts three (3) implementing partners through service level agreements.
- USAID grant has 12 Sub-recipients

Implementing Stakeholders under GF and USAID

GF		USAID	
IS	Priority Area	IS	Priority Area
JASL (SR)JFLAG, JN+, JCW+ & EFL	Prevention, EEHR & TCS EEHR & TCS	JASL (SR)	Prevention, TCS and EEHR
ASHE (SR) RISE	Prevention Prevention	ASHE (SR)	Prevention
Children First (SR) HWW	Prevention Prevention	Children First (SR)	Prevention
NFPB-SHA (SR) MLSS, JEF, UWIHARP	Prevention & EEHR EEHR & HSS	Jamaica Red Cross (SR)	Prevention
MOH/NERHA	TCS & Prevention	JFLAG (SR)	EEHR
MOH/SERHA	TCS & Prevention	JN+ (SR)	EEHR
MOH/WRHA	TCS & Prevention	NFPB-SHA (SR)	Prevention & EEHR
MOH/SRHA	TCS & Prevention	NERHA (SR)	TCS & Prevention
MOH/NCDA	Prevention	SERHA (SR)	TCS & Prevention
MOH/Children of Faith	TCS & Prevention	WRHA (SR)	TCS & Prevention
		SRHA (SR)	TCS & Prevention
		CHARES (SR)	TCS

IMPLEMENTING GRANTS

Implementing a new grant with new strategies, increased KP targets came with its own challenges.

- During 2016, the Global Fund, USAID and Ministry of Health underwent a restructuring process. The restructuring created delays that impacted the timely implementation of the grants.

- In an effort to improve the financial management systems, measures including the implementation of a new financial reporting template and monthly disbursements of funds to the entities were implemented. During the period, the Principal Recipient (PR) worked with the implementing entities to address challenges with the timely disbursement of funds and submission of financial and technical reports.
- A series of Grant Management trainings were implemented. The PR increased the number of one-on-one training and work plan review meetings.
- During the year, the GF Country Portfolio Manager changed twice. This negatively impacted the timely approval of reallocation request as each change required time for the new manager to become familiar with the work plan and concept note.
- The PR conducted site visits and meetings with the stakeholders in an effort to improve implementation strategies. During the visits, implementing entities discussed possible solutions for the following reoccurring challenges:
    - » *meeting the TG targets*
    - » *recruiting and retaining staff due to unsatisfactory remuneration package*
    - » *finding candidates with the right skill sets and attitude (for e.g. peer navigators & links)*
    - » *finding suitable candidates to fill the position of Adolescent Psychologist*
    - » *receiving less funds than was requested from PR – without notification and reason for change*
    - » *the turnaround time for entities to receive and access monthly disbursements*
    - » *improving expenditure by scaling up of the implementation of activities*
- The challenges were shared with the JCCM and they provided technical support aimed at resolving the challenges with meeting the TG targets and finding candidates with the right skill sets.
- Due to lengthy delays in the procurement processes, the MOH explored the possibility of using the GF online procurement mechanism, WAMBO, to procure health products. The proposal was presented to the government and the use of WAMBO was approved.
- It has been a challenge finding suitable candidates to fill the position of Adolescent Psychologist. To alleviate this concern, the SRs and PR have been discussing the matter with the training institutions and experts in the field.

SUMMARY OF CHALLENGES – TECHNICAL AREAS:

Prevention

1. The internal migration of KPs resulted in ongoing challenges with duplication of testing. Reaching the MSM population was a challenge, considering the high targets and the process of de-duplication. De-duplication process has had a negative effect on the moral of the outreach staff and the working relationship between implementing entities as is expected when a new system is implemented

2. Low testing yield occurred for a few months during the period because of crime and violence in Western region and St Catherine.
3. Meeting the reach and test SW target was also challenging because interventions which provided stipend/venue (workshop) costs were not included in the outreach strategy. The decision to not include empowerment and skills building interventions in the strategy was based on the SW prevalence rate which was reduced to 2.9% according to the 2014 SW survey.
4. The unavailability of lubes to distribute with the condoms.
5. The recruitment and retention of suitable peer links were challenging for implementing partners.
6. MSM are not readily taking up the offer of further education as most of them are dealing with adverse life events such as homelessness, low self-esteem and lack of coping skills to manoeuvre the adverse social, cultural and economic environment.
7. New MSM who want to remain hidden are not willing to participate in venue based interventions with other MSM that they don't know.

EEHR

1. Identifying suitable candidates with the requisite skills to conduct situation analysis, guidelines and protocols and develop training materials related to S&D is challenging because there is a limited number of local persons and sometimes they are not available.
2. The lack of a standardized tracking and monitoring tool for S&D activities/interventions makes it difficult to produce evidence of the impact of these activities/interventions.
3. Added layers of stigma among PLHIV and key populations continued to be a barrier to recruitment and securing commitments for greater involvement of PLHIV and key populations. E.g.: fear of involuntary disclosure through peer groupings or by association.
4. Despite achieving targets for sensitization of the NHDRRS among PLHIV and KP, numbers of documented complaints to the HIV-related discrimination reporting and redress system are suboptimal.

TCS

1. The MOH procurement processes have negatively impacted the length of time it takes to purchase test kits.
2. The implementation of support group meetings/activities are not standardized across the entities hence it is difficult to track their effectiveness.
3. Efforts to increase Retention in Care (RTC) can be daunting because some of the patients contact information is not up to date and hence the telephone numbers are no longer in service and the home addresses are either incorrect or persons have moved to another location.
4. Significant delays in hiring consultants - Identifying suitable candidates with the requisite skills to conduct research or studies are limited and are sometimes not available. This challenge contributed to delay in the development and roll out of the adherence protocol.

MER

1. Ownership, monitoring and use of the treatment site database continue to impact negatively on the timely implementation of the improvement actions that would complete the data cleaning process.
2. Due to the lengthy process to achieve ethical approval, major studies (KAPB and MSM) did not commence in 2016.
3. Significant delays were encountered with the unavailability of local expertise to develop a UIC electronic system using DHIS2 database software.
4. Significant delays in hiring consultants - Identifying suitable candidates with the requisite skills to conduct research or studies are limited and are sometimes not available. This challenge contributed to the delay in the consultancy to identify barriers to access to treatment, care and support for positive MSM and SW.

LESSONS LEARNT – TECHNICAL AREAS:

Prevention

1. The peer link strategy has proven to be successful at mobilizing members of the KP community. It has created opportunities to reach and test KPs who are hidden and want to remain hidden. However the recruitment process and subsequent training should be revised to reduce the risk of high attrition.
2. It is extremely important to put systems in place to ensure KP information is kept confidential because breaches will have a negative effect on the willingness of KPs to test and provide personal information.
3. The use of social media has been useful in reaching some hidden members of KPs because they can access information without being seen however there needs to be a mechanism to track the reach.
4. Home-based intervention has been successful because the clients select the venues which are private and safe. Like the peer link strategy, the privacy factor limits the possibility of physically monitoring and validation of these interventions

EEHR

1. To reduce the significant delay experienced when partnering with the RHAs, each region should develop and distribute a guideline that clearly states the procedure and timeline required to approve a request for collaboration and joint implementation of interventions with other implementing entities.
2. In the absence of S&D tracking and monitoring tool/system, improving the NHDRRS will remain challenging.

TCS

1. In the absence of an evaluation of the support group mechanism, monitoring and tracking

its effectiveness will remain challenging.

M&E

1. Continuous monitoring and efforts to increase ownership of the treatment site and Unique Identifier Code (UIC) database are required to achieve/sustain data quality and use.

CHAPTER 8: PROCUREMENT

OVERVIEW

The Procurement Unit continued to lead in the strategic procurement of third party goods and services in 2016 ensuring consistency in supply and delivering the best value and quality in accordance with procurement guidelines. The total value of contract awarded for goods, services, consulting and non-consulting services in 2016 was $451.5 million. For those contracts awarded, 96.8% was through competitive bidding process and 3.2% awarded through non-competitive process.

Procurement activities were guided by the Government of Jamaica and the donor agencies procurement guidelines. This guidelines are built on the underlying principles such as: equity and fairness; transparency; economy and efficiency; and equal opportunity. Open competition was emphasized as the basis for efficient public procurement and the most appropriate method in conducting procurement activities was selected. Harmonization of procurement policies and procedures was ongoing through capacity building.

One of the Unit's objectives for 2016 was to become more involved with its internal customers and external partners. To this end, the Unit set to gain a better understanding of their needs and made recommendations for increasing efficiency and effectiveness.

While significant progress was made to make the procurement process more efficient, the Procurement Unit continued to pursue additional improvements in the procurement process. The activities going forward seek to enhance institutional effectiveness for results through a focus on: (i) results and performance; (ii) streamlining internal processes; (iii) strengthening capacity building; and (iv) leveraging resources to deliver.

IMPROVING PROCUREMENT EFFICIENCY

E-Procurement System

To strengthen the efficiency and quality of Jamaica's public procurement process, the Ministry of Finance and Planning implemented Jamaica's first electronic procurement platform in 2016. The e-Procurement System, launched under the theme: 'Faster, Easier and More Efficient Way of Doing Business', is in keeping with the Government's commitment to strengthen and promote Public Procurement Reform under the Economic Reform Programme (ERP). This system will significantly improve efficiency and transparency in the acquisition of goods, services and works, reduce administrative costs, and improve processing time.

Some 2,000 persons, including procurement practitioners and suppliers, will be trained over a 12-month. Some of the features of the system are: online access to procurement legislation and regulations for all agencies and stakeholders; online advertising of bids; downloading of bid documents; contract award publication; electronic bid submission; e-mail notification of new bids to suppliers and; and an electronic procurement management information system that facilitates audit, as well as the extraction of data for statistical purposes.

Specialist Sector Committees

In July 2016, the National Contracts Commission established five (5) new Specialist Sector Committees to facilitate the timely processing of submissions for awarding contracts. These are: (i) Goods Specialist Sector Committee; (ii) Consulting and General Service Specialist Sector Committee; (iii) Insurance Specialist Sector Committee; (iv) Works Specialist Sector Committee; (v) Information, Communication and Telecommunication (ICT) Specialist Sector Committee. Procuring entities are no longer assigned to a specific Sector Committee. Submissions are now directed to the Chairman of the specific Specialist Sector Committee assigned to review a particular type of procurement. This will significantly reduce the processing time to award contract, resulting is faster delivery and project execution time.

CAPACITY BUILDING

During the year, the Unit conducted training workshops for both project staffs and implementing partners in Procurement Management. The training delivered included: procurement policies and procedures, procurement planning, managing suppliers, contract management and managing risks. The objectives of this training was to enhance their skills in procurement rules and procedures, simplify procurement processes, increase efficiency

and effectiveness, and reduce transaction processing time. In addition to leading training workshops, one-on-one training with internal staff and implementing partners was done to help in resolving problems specific to each entity. The sessions covered topics such as, developing specifications, preparing Request for Quotation (RFQ) document, and applying the public procurement process. Site audits were also conducted quarterly to assess compliance, governance and risk management.

Capacity building for Procurement practitioners was also a key initiative in 2016. Procurement officers participated in a mandatory public procurement training and certification course. The training was done in partnership with the International Procurement Institute (INPRI), and covered key concepts, principles and applications in Public Sector Procurement. It comprises four (4) levels of certification and included internationally accepted best practices and developments in electronic government procurement.

The XII Annual Conference of Government Procurement in the Americas was held during the period November 29 - December 1, 2016, in Montego Bay. The theme of the conference was "Public Procurement – a Tool for Economic Development. The conference provided an important platform for the exchange of knowledge, experiences, best practices and lessons learned in the ongoing effort to modernize public procurement in the Latin America and Caribbean region and beyond.

The first two days of the event were organized around plenary sessions on the topics: lessons learned and challenges in public procurement in the Caribbean, governance of public procurement systems, sustainable public procurement, e-procurement, best practices and the evaluation of public procurement systems, open data and the strategic use of statistics in public procurement, professionalization of public procurement, new tendencies and innovation in public procurement.

CHAPTER 9: FINANCE

OVERVIEW

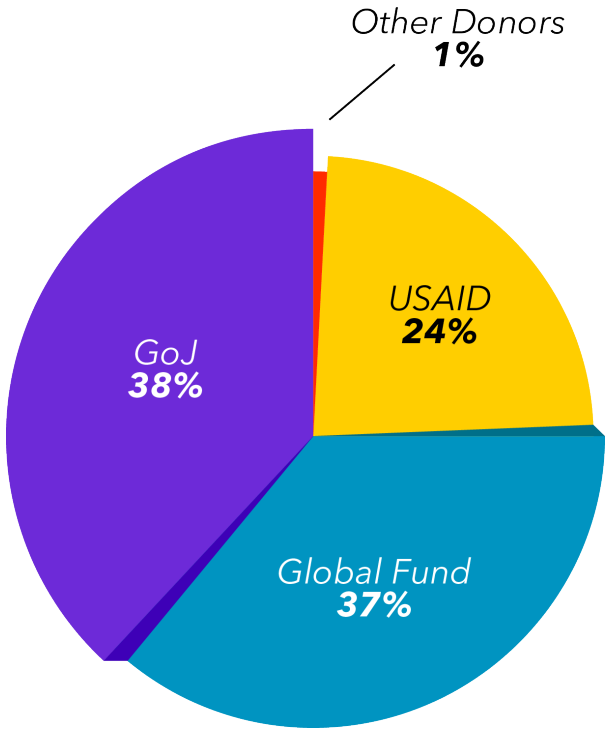
The framework for the HIV/AIDS response is primarily guided by the National Integrated Strategic Plan on HIV and SRH and specific objectives of Vision 2030 Jamaica, the National Development Plan. From the late 1990s, the United States Agency for International Development (USAID) and subsequently in 2003, the Global Fund to fight AIDS, Tuberculosis and Malaria (GF) were the primary from donors providing grant resources for the National Programme (NP). During 2016, however the Government of Jamaica (GoJ) through its cash allocation became the largest contributor to the national response. The Government of Jamaica also provided in kind contributions, as it had done in previous years.

The funding from the Global Fund New Funding Mechanism (NFM), a new grant, valued at US$15.24M commenced in January 2016 and is expected to end in December 2018. Under its Development Assistance Agreement No. 532-DOAG-2013-JM entitled "Threats to the Environment and Citizens Vulnerability Reduced", USAID provided funding across three implementation agreements. These agreements - USAID transitional, Year 5 Implementation letter (IL) 3 , (532-IL-532-HE-DOAG-00003) and Year 6 Implementation letter (IL) 4 (532-IL-532-HE-DOAG-00004) - which started in October 2016 at the Principal Recipient (PR) level, overlapped within the calendar year of 2016.

The budgetary contribution for the HIV/AIDS response for the year 2016 was J$1.68B; this represents an approximately 55.16% (or J$598.24M) increase over the previous year. The total Government of Jamaica contributions through the recurrent budget and through its contribution towards the USAID & Global Fund grant funded projects, was J$646.54M. The GoJ's contributions in 2016 represents an increase of approximately 45% when compared with the amount committed in 2015 (J$353.59M).

The Global Fund was the second largest contributor to the national response for the period under review. The Global Fund's support accounted for 37% (J$629.47M) of budgetary allocation and a 44% increase in contributions when compared with 2015

Figure 14: Budgetary Contribution by Funding Source, 2016



Source: National HIV/STI/Tb Unit Financial Statements

EXPENDITURE

The Unit projected that expenditure for the Programme for the calendar year 2016 would have been J$1.68b. This was expected to represent an increase of approximately 55% over the previous year's projection (J$1.08b). Actual expenditure for the year was J$1.39b, this represents a burn rate of over 83% of the budgeted amount.

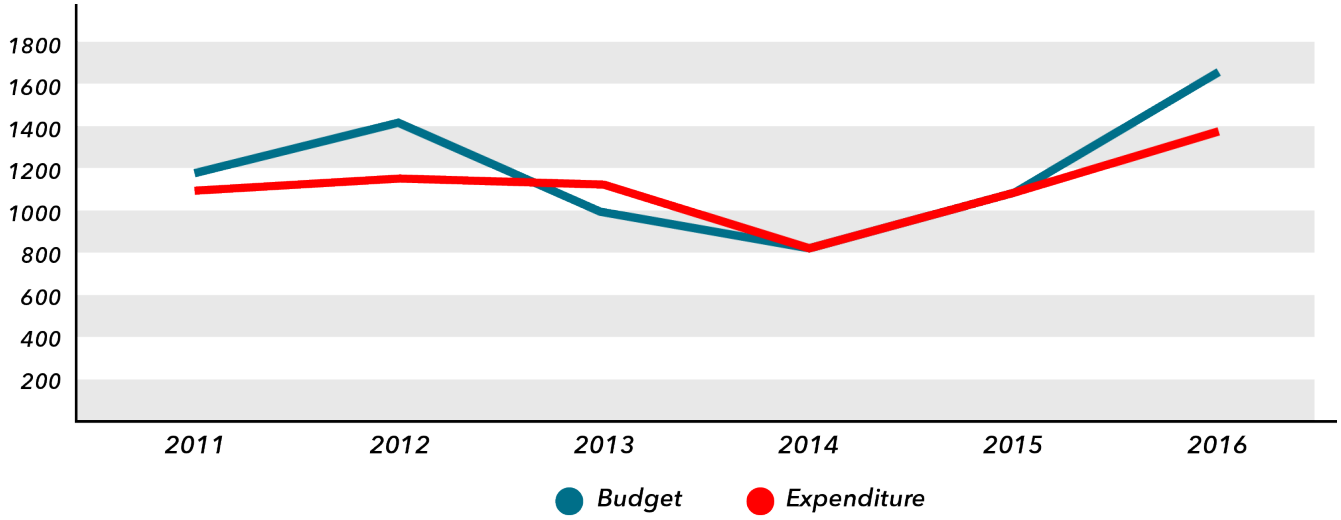
The main area of under expenditure was from the USAID Grant, which only utilized 75% of the allocation for the year. This is mainly due to an extension of the Year 5 activities that were slated to end within the year. This resulted in related expenditures being incurred beyond the reporting period. For the calendar year 2016, Year 6 (which commenced in October 2016), was only being implemented at the Principal Recipient level within the calendar year

2016 as the SRs were slated to come on board in January 2017.

The Principal Recipient expenditure for the calendar year was J$808.34M or 58%, while J$584.44M was spent at the field level by the Sub-recipients (SRs).

Figure 15 below illustrates the Programme budget allocation compared to the Programme expenditure for the years 2011 to 2016. The cash basis of accounting is applied in the Programme. .

Figure 15: National HIV/STI Expenditure by Calendar Years (J$M) 2011/2016



Source: National HIV/STI/Tb Unit Financial Statements

Prevention

The National Family Planning Board (NFPB) is the technical lead for all prevention interventions for the national response. The budget for the prevention component in 2016 was J$520.29M. This allocation is approximately 80% more than what was allocated in 2015. The prevention unit expended J$441.01 or 85% of its budget allocation.

The activities for the prevention component focused on activities aimed at reducing the spread of HIV and they are targeted to most at risk populations and the general population. The Prevention component team work entails peer education and outreach, skills-building training for vulnerable groups, training and capacity building for the CSOs that are implementing prevention activities and the procurement of condoms and HIV test kits. Additionally, funding was used to cover staffing costs.

The majority of the funding for the prevention component are spent at the SRs level. The activities are implemented by the Ministry of Health, Regional Health Authorities and Non-Government Organizations.

Treatment, Care and Support (TCS)

The TCS component of the national response is focused on ensuring that there is a comprehensive system of care for PLHIV. The comprehensive system of care includes adherence counselling efforts, monitoring and preventing ARV resistance and improving standardization of method of tracking adherence and ARV resistance.

The activities under this component include the procurement of ARV drugs, test kits, reagents, provision of alternative nutrition for new-borns of HIV infected mothers and the rolling out of the case management and adherence protocols. Overall access to care increased significantly, as such there, was over a 100% ($389.16M) increase in the amount allocated to this component when compared with 2015.

During the reporting year, J$757.18M was allocated to the component. Of that figure, J$318.24M or 42% was from the GoJ purse. The funding support for the component that was provided by GoJ in 2016, was more than two times what was allocated in 2015.

Of the J$757.18M that was allocated to the component, J$656,68M was expended. The under expenditures were largely attributed to the USAID Grant resources.

Enabling Environment/Advocacy & Policy

The activities in this component are implemented to operationalize HIV policies. These policies are introduced to empower beneficiaries in terms of understanding their rights and seeking redress in instances where rights are abused. For 2016, significant progress was made through the collaborative efforts of NFPB and the Jamaica AIDS Support for Life (JASL). The activities during the year focused on the use of the PHDP curriculum with PLHIVs during sensitization sessions, validating and finalizing the policy monitoring and assessment tool, implementing strategies for achieving an effective redress framework and the development and implementation of the policy and protocol on referral mechanism. For the year 2016, J$46.91m was budgeted, of which J$44.16 or 94 % was expended. Funding for the component was made largely available through the Global Fund resources.

Monitoring & Evaluation

In 2016, J$63.21M was allocated for Monitoring & Evaluation activities. This was an increase of J$24.74M when compared with 2015. Expenditure for the period was J$23.33M or 37% of the budget allocation. The resources from Global Fund contributed J$30.58M to the component however, only J$9.59M was liquidated. The USAID contributed J$29.31M of which J$10.07M was expended.

Notwithstanding the low expenditure, two significant achievements under the component were 1) the implementation of the Unique Identifier Code (UIC) for PLHIVs and, 2) the establishment of DHIS2 which links the database at all the treatment sites throughout the country for HIV patient management. The procurement of the NVIVO software and STATA to facilitate data analysis was also done during the year.

Capacity Building/Administration

The Capacity Building/Administration component ensures that the resources are managed efficiently and that the Programme recruits and retains suitable and qualified staff. During the reporting period, funds were spent to deliver training and capacity building activities for the staff.

In 2016, 295.25M was allocated for Capacity Building/Administration, of which J$227.61M or 77% was spent. The majority of the spending occurred in the following areas: staffing, administrative fees for the SRs, audit costs, the upgrade and implementation of the accounting software, site reviews for SRs and workshops.

Figure 16: Comparison of the budget and expenditure, by components (2013 to 2016)

Components	Calendar Year 2013		Calendar Year 2014		Calendar Year 2015		Calendar Year 2016	
	Budget J$M	Actual J$M	Budget J$M	Actual J$M	Budget J$M	Actual J$M	Budget J$M	Actual J$M
Cash Basis								
Prevention	301.64	440.69	329.17	311.15	288.79	285.01	520.29	441.01
Treatment, Care & Support	329.21	433.64	175.00	189.41	368.02	345.03	757.18	656.68
Monitoring & Evaluation	14.19	9.50	23.68	30.56	38.47	33.75	63.21	23.33
Capacity Building/ Administration	50.24	57.24	247.38	263.16	334.50	374.42	295.25	227.61
Enabling Environment/Policy	268.72	187.72	62.95	44.03	54.81	62.14	46.91	44.16
Health Sector	42.66	8.14	-	-	-	-	-	-
Sub Total	1,066.66	1,136.94	838.19	838.32	1,084.34	1,100.34	1,682.83	1,392.79
In-kind Contribution		67.54		73.35		80.69		68.59
Grand Total	1,066.66	1204.48	838.19	911.67	1,084.34	1,181.03	1,682.83	1461.37

Source: National HIV/STI/Tb Unit Financial Statements

The funding from the Global Fund NFM commenced in 2016 and is slated to end in December 2018, total value of the grant is US$15.24M. The resources of the Project were primarily used for the procuring of ARVs, testing supplies, condoms, covering staff cost (especially at the SRs) and scaling up of prevention and advocacy activities. The approved budget for 2016 was J$629.47M; this is a 44% increase when compared with the allocation for 2015. During the reporting period, J$578.00M or 92% of the budget was liquidated; of that figure, J$85.49M is tied to the commitments from Global Fund Transitional Funding Module (TFM) that ended in Dec 2015 that were settled in the 2016 calendar year. From the variance of J$136.93M that exists at the end of year 1 of the Global Fund NFM grant., J$30.76M was committed and the balance was submitted in a reprogrammed year 2 (Jan -Dec 2017) budget submitted to the Global Fund for approval.

FUNDING SOURCES

During the reporting year, there were three USAID PEPFAR agreements being implemented concurrently. The funding for the Transitional period was extended and finalized within the reporting year. A portion of USAID year 5 was liquidated within the year and USAID year 6 commenced at the PR level only within the year. The total budget allocated under the Grants

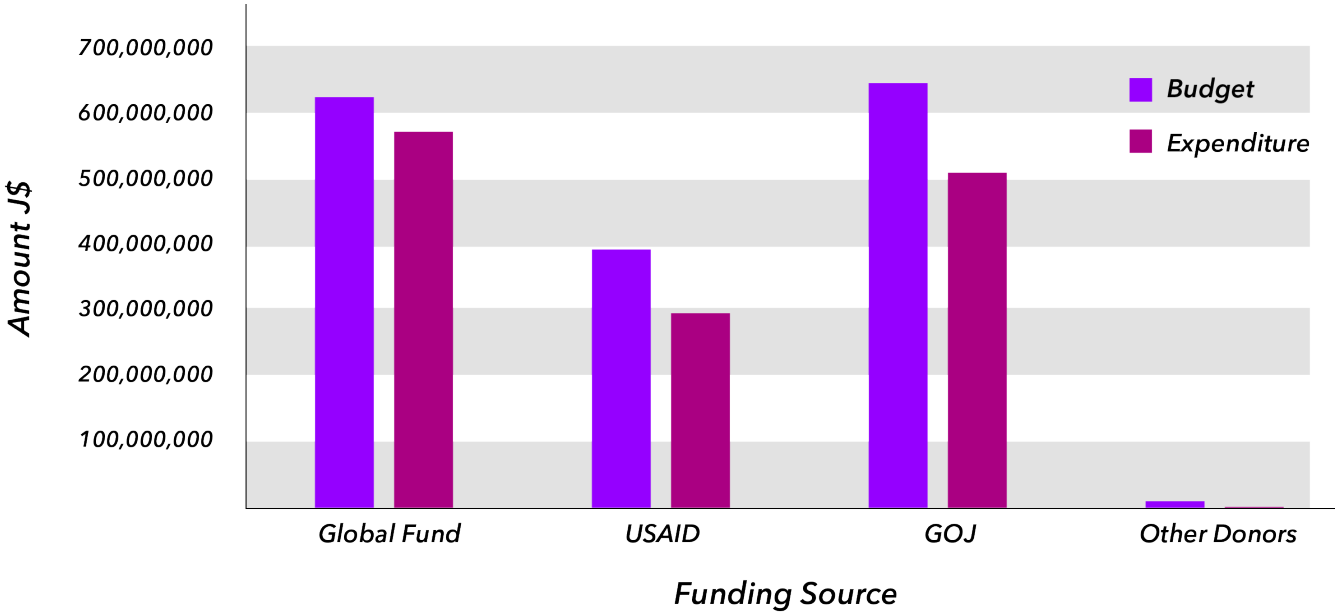
to the Programme was J$395.65M, this is a 40% increase in the amount budgeted over the previous year. Even though the budget was more in this calendar year, the expenditure during the period was 7% less than that of 2015 as only J$296.47M was expended. The resources of the grant are liquidated both at the PR and SR levels, J$171.69M or 58% of the expenditure for the year was at the SR level. The funds were used to support key populations groups and PLHIVs in accessing the Continuum of Prevention, Care and Treatment (CoPT), reduce stigma and discrimination and improve the protection of the right of selected vulnerable groups and support capacity of stakeholders.

The Government of Jamaica (GoJ) ramped up its contribution to the Programme significantly during 2016 through the Recurrent budget and through its contributions to the USAID and Global Fund Grants. In 2015, the GoJ contributed J$31.93M, J$37.94 and J$283.72M to the Global Fund contribution, USAID contribution and Recurrent budget respectively, when compared with J$75.88M J$94.87M and J$475.79M in 2016. In total J$646.54M was budgeted during 2016 of which J$513.56M or 80% was expended. A significant portion of the contribution received from GoJ was used to support staff cost and finance activities under the TCS component through the procurement of infant formula, test kits and ARVs.

During the year the Programme benefited from J$68.59 in-kind contribution from the Government of Jamaica (GoJ). These activities include salaries, office space rental and maintenance, security and janitorial costs.

The diagram below shows an analysis of the budget and expenditure for the respective funding sources during 2016.

Figure 17: Budget vs expenditure by funding source, 2016



Source: National HIV/STI/Tb Unit Financial Statements

CHALLENGES

- During the reporting year the Programme was faced with several challenges. These include:
- Significant delay in the implementation of the ACCPAC software, which created significant bottle necks.
- The late submission of the USAID audit report.
- The withdrawal of electronic banking services due to unauthorized withdrawals from our bank accounts.
- Delays experienced with payments being made under the Recurrent budget, and difficultly in receiving confirmation for payments made.
- Insufficient monitoring of the SRs as a result of fewer site visits being conducted than were planned.
- The inability to meet the training demands from the SRs. The number of requests received from out-stations, the quality of reports submitted and the findings from the audit report indicate a great need for support. There is a need to strengthen of the internal control of the finance units both at the PR and the SRs levels.

Despite these challenges the Unit was able to submit on-time quarterly progress reports to the Global Fund and the Expenditure Analysis Report to USAID. The Unit developed a procurement and finance checklist as a tool to guide implementation. In terms of improving operational efficiency, the Unit provided support to the rolling out of the PR operational manual, and contributed to the drafting of the SR operational manual.

Appraisals

The close-out financial audit for the period April 2015 to March 2016 for USAID was due on December 31, 2016. The Unit requested an extension of the deadline to February 2017 due to software bottlenecks. The audit was conducted by BDO audit firm.

The Global Fund audit, which covers the period January to December 2016, is due to the Global fund on March 31, 2017. The audit will be conducted by Mair Russell Grant Thorton who has a three-year contract to conduct the NFM audit, as instructed by the Global Fund.

HIV & AIDS
FACTS AND FIGURES
2016

DATA TABLES

Table 1: Summary of HIV cases reported by Year and Sex, 1982 to 2016

Year	Male (%)	Female (%)	Unknown (%)	Total
1982 to 1995	2114 (63.8)	1166 (35.2)	33 (0.1)	3313
Jan - Dec 1996	574	388	4	966
Jan - Dec 1997	690	427	2	1119
Jan - Dec 1998	633	426	1	1060
Jan - Dec 1999	801	626	2	1429
Jan - Dec 2000	820	696		1516
Jan - Dec 2001	827	807	5	1639
Jan - Dec 2002	728	679	1	1408
Jan - Dec 2003	833	823	1	1657
Jan - Dec 2004	852	994		1846
Jan - Dec 2005	874	1019		1893
Jan - Dec 2006	986	1083	1	2070
Jan - Dec 2007	915	992	2	1909
Jan - Dec 2008	865	985		1850
Jan - Dec 2009	819	887		1706
Jan - Dec 2010	788	736		1524
Jan - Dec 2011	890	879		1769
Jan - Dec 2012	785	727		1512
Jan - Dec 2013	670	586		1256
Jan - Dec 2014	649	622		1271
Jan - Dec 2015	597	579		1176
Jan - Dec 2016	1056	958		2015
Total	18766	17058	52	35904

Table 2: Summary of Persons with advanced HIV* in Jamaica, 2005 to 2016

Year	Total	Male (%)	Female (%)
Cumulative 1982-2016	23091	12613	10478
Jan - Dec 2005	1327	688	639
Jan - Dec 2006	1181	657	524
Jan - Dec 2007	1083	585	498
Jan - Dec 2008	1194	616	578
Jan - Dec 2009	1474	697	777
Jan - Dec 2010	1490	708	782
Jan - Dec 2011	1241	658	583
Jan - Dec 2012	1870	934	936
Jan - Dec 2013	774	422	352
Jan - Dec 2014	749	397	352
Jan - Dec 2015	640	328	312
Jan - Dec 2016	916	522	394

*In July 2005, the national programme began monitoring cases of advanced HIV (i.e. persons with CD4 counts < 350). Figures reported for AIDS cases between July 2005 and December 2007 included persons with advanced HIV.

Table 3: Summary of AIDS cases in Jamaica, 1982 to 2016

Year	Male (%)	Female (%)	Total
1982 to 1995	979	576	1555
Jan - Dec 1996	304	184	488
Jan - Dec 1997	372	237	609
Jan - Dec 1998	410	233	643
Jan - Dec 1999	538	352	890
Jan - Dec 2000	514	384	898
Jan - Dec 2001	508	426	934
Jan - Dec 2002	571	402	973
Jan - Dec 2003	603	451	1054
Jan - Dec 2004	602	506	1108
Jan - Dec 2005	688	639	1327
Jan - Dec 2006	657	524	1181
Jan - Dec 2007	441	333	774
Jan - Dec 2008	524	399	923
Jan - Dec 2009	491	413	904
Jan - Dec 2010	497	430	927
Jan - Dec 2011	541	430	971
Jan - Dec 2012	628	558	1186
Jan - Dec 2013	383	297	680
Jan - Dec 2014	309	226	535
Jan - Dec 2015	238	193	431
Jan - Dec 2016	472	343	815
Total	11270	8536	19806

Table 4: Summary of HIV cases by Parish in Jamaica, 1982 – Dec 2016 (by date of reporting)

PARISH	Jan - Dec 2016	1982 - Dec 2016 Cumulative Total	RATE PER 100,000 POPULATION 2016
Kingston & St Andrew	682	12590	96.45056
St Thomas	68	615	34.70506
Portland	68	820	39.86904
St Mary	59	1206	20.8614
St Ann	111	2547	43.55975
Trelawny	67	1002	42.05049
St James	168	4708	71.51114
Hanover	71	948	51.15526
Westmoreland	140	2049	71.9898
St Elizabeth	59	969	15.78179
Manchester	104	1282	35.90421
Clarendon	114	1887	31.84367
St Catherine	217	4869	34.86209

Table 5: Summary ofcAIDS cases by Parish in Jamaica, 1982 -2015 (by date of reporting)

PARISH	Jan - Dec 2016	1982 - Dec 2016 Cumulative Total	Rate per 100,000 population 2016
Kingston & St Andrew	457	7360	68.12659
St Thomas	15	317	15.77503
Portland	19	409	22.9549
St Mary	22	631	19.12295
St Ann	26	1215	14.90202
Trelawny	12	541	15.76893
St James	41	2849	22.04479
Hanover	16	491	22.73567
Westmoreland	38	1161	26.05345
St Elizabeth	10	515	6.575746
Manchester	28	680	14.56983
Clarendon	31	912	12.49562
St Catherine	93	2686	17.81415
Parish Unknown	7	26	n/a
Overseas address		13	n/a
Total	815	19806	29.84371

Table 6: Summary of AIDS deaths in Jamaica, 1982 – dec 2016

Year	Total	Male (%)	Female (%)
1982 to 1999	2513	1591	922
Jan - Dec 2000	616	359	257
Jan - Dec 2001	587	329	258
Jan - Dec 2002	687	402	285
Jan - Dec 2003	649	380	269
Jan - Dec 2004	663	378	285
Jan - Dec 2005	510	307	203
Jan - Dec 2006	431	263	168
Jan - Dec 2007	319	202	117
Jan - Dec 2008	400	236	164
Jan - Dec 2009	377	234	143
Jan - Dec 2010	333	198	135
Jan - Dec 2011	392	234	158
Jan - Dec 2012	256	155	101
Jan - Dec 2013	298	169	129
Jan - Dec 2014	217	121	96
Jan - Dec 2015	255	137	118
Jan - Dec 2016	327	190	137

Table 7: Summary of AIDS death by Parish in Jamaica, 1982 – Dec 2016 (by date of reporting)

Parish	Jan- Dec 2016	1982 - Dec 2016 Cumulative Total
Kingston & St Andrew	139	3661
St Thomas	1	120
Portland	12	214
St Mary	14	371
St Ann	25	438
Trelawny	7	303
St James	18	1613
Hanover	13	304
Westmoreland	16	666
St Elizabeth	13	281
Manchester	25	334
Clarendon	9	277
St Catherine	35	1220
Parish Unknown		12
Overseas address		7
Total	318	9821

Table 8: Summary of paediatric AIDS cases (age 0 - 9 years), 1986 – 2016

Year	Male (%)	Female (%)	Total
1986- Dec 2016	500	440	940
Jan - Dec 2000	49	34	83
Jan - Dec 2001	37	26	63
Jan - Dec 2002	37	44	81
Jan - Dec 2003	36	30	66
Jan - Dec 2004	27	30	57
Jan - Dec 2005	37	29	66
Jan - Dec 2006	36	36	72
Jan - Dec 2007	13	11	24
Jan - Dec 2008	13	11	24
Jan - Dec 2009	13	8	21
Jan - Dec 2010	7	8	15
Jan - Dec 2011	11	3	14
Jan - Dec 2012	7	5	12
Jan - Dec 2013		4	4
Jan - Dec 2014	4	2	6
Jan - Dec 2015	1	1	2
Jan - Dec 2016	1		1

Table 9: Summary of Paediatric AIDS cases by Parish in Jamaica (by date of reporting), 1986 – 2016

PARISH	Cumulative Total	Rate per 100,000 population Cumulative Total
Kingston & St Andrew	384	289.2655
St Thomas	25	118.957
Portland	16	89.65595
St Mary	29	115.9073
St Ann	35	94.10879
Trelawny	16	97.91922
St James	123	313.6635
Hanover	17	113.9563
Westmoreland	38	121.1194
St Elizabeth	22	70.99293
Manchester	37	93.41783
Clarendon	52	92.63878
St Catherine	143	135.8115
Parish Unknown	2	n/a
Overseas address	1	n/a
Total	940	165.5833

Table 10: Summary of Paediatric AIDS deaths, 1986 -2016

Year	Total	Male (%)	Female (%)
1986 to Dec 2016	425	219	206
Jan - Dec 2000	34	20	14
Jan - Dec 2001	27	14	13
Jan - Dec 2002	45	22	23
Jan - Dec 2003	28	17	11
Jan - Dec 2004	32	16	16
Jan - Dec 2005	16	11	5
Jan - Dec 2006	12	10	2
Jan - Dec 2007	8	4	4
Jan - Dec 2008	8	3	5
Jan - Dec 2009	4	3	1
Jan - Dec 2010	7	6	1
Jan - Dec 2011	1	1	
Jan - Dec 2012	6	4	2
Jan - Dec 2013	2		2
Jan - Dec 2014	3	2	1
Jan - Dec 2015	1		1
Jan - Dec 2016	1		1

Table 11: Summary of AIDS cases by 5-year age groups, 1986 – Dec. 2016, Jamaica

Age Group	Male	Female	Total
00 to 4	367	311	678
05 to 9	94	96	190
10 to 14	45	58	103
15 to 19	74	205	279
20 to 24	475	731	1206
25 to 29	1173	1261	2434
30 to 34	1619	1422	3041
35 to 39	1851	1314	3165
40 to 44	1662	1027	2689
45 to 49	1310	710	2020
50 to 54	1029	477	1506
55 to 59	686	361	1047
60 to 64	397	233	630
65 to 69	205	127	332
70 to 74	94	71	165
75 to 79	44	32	76
80 to 84	10	17	27
85 to 89	3	4	7
90 to 94		3	3
Unknown	132	76	208
Total	11270	8536	19806

Table 12: Adult HIV cases by sexual practices (1982 – Dec 2016 cumulative)

Sex Practice Category	Male	Female	Unknown	Total
Bisexual Males	735			735
Heterosexual	8595	16059		24654
Homosexual	726			726
Not Stated	7615		29	7644
Total	17671	16059	29	33759

Child	831	762	23	1616
Total	18502	16821	52	35375

Table 13: Reported risk behaviours among adults with HIV (1982 – Dec 2016 cumulative)

Risk	No. of persons (%)
Crack, Cocaine User	1,396
History of STI	11691
IV Drug Use	206
Multiple Sexual Partners/ contacts	5500
No high risk behaviour	4939
Sex With Sex workers	4497

Table 14: HIV Status of Pregnant Women by Parish 2016*, Jamaica

PARISH	Total Tested	Total Positive	% Positive	(95% CI) Exact
Kingston & St Andrew	1547	12	0.78	0.40 – 1.35
St Catherine	1161	8	0.69	0.30 – 1.35
St Ann	569	5	0.88	0.29 – 2.04
Clarendon	781	6	0.77	0.28 – 1.66
St James	464	4	0.86	0.24 – 2.19
Westmoreland	695	4	0.58	0.16 – 1.47
TOTAL	5217	39	0.75	0.53 – 1.02

**Survey conducted between September 2016 and May 2017*

Table 15: HIV status of STI Clinic attendees by Parish 2016*, Jamaica

PARISH	Total Tested	Total Positive	% Positive	(95% CI) Exact
Kingston & St Andrew	1291	63	4.88	3.77 – 6.20
St Catherine	332	9	2.71	1.25 – 5.08
St Ann	617	7	1.13	0.46 – 2.32
Clarendon	245	2	0.82	0.10 – 2.92
St James	283	10	3.53	1.93 – 6.38
Westmoreland	38	1	2.63	0.07 - 13.81
TOTAL	2806	92	3.28	2.65 – 4.01

**Survey conducted between September 2016 and May 2017*

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