NATIONAL HIV/STI PROGRAMME

ANNUAL REPORT 2017

Ministry of Health

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This document presents the National HIV/STI Programme report covering the period January to December 2017. It reflects the implementation of the National Integrated Strategic Plan 2014 – 2019 through the outstanding coordination of the HIV/STI/Tb Unit in collaboration with the National Family Planning Board, other government agencies, civil society organizations and the private sector.

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This report was compiled through the combined efforts of many individuals in the Ministry of Health. The Ministry of Health acknowledges the leadership of the National HIV/STI/Tb Unit and the National Family Planning Board – Sexual Health Agency (NFPB-SHA) in the completion of this report.

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
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behaviour Change Communication
CD4	Cluster of Differentiation
CBO	Community-based Organization
CCM	Country Coordinating Mechanism
CF	Community Facilitators
CM	Case Manager
CRH	Cornwall Regional Hospital
CSO	Civil Society Organization
CVCC	Caribbean Vulnerable Communities Coalition
DHIS2	District Health Information System 2
EEHR	Enabling Environment and Human Rights
EMTCT	Elimination of Mother-To-Child Transmission
FAACC	Fort Augusta Adult Correctional Centre
FACS	Fluorescence-activated Cell Sorting
FHU	Family Health Unit
FSW	Female Sex Worker
GIPA	Greater Involvement of Persons with HIV/AIDS
GIS	Geographic Information System
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOJ	Government of Jamaica
GPS	Global Positioning System

HARC	Horizon Adult Remand Centre
HATS	HIV/AIDS Tracking System
HCW	Health Care Worker
HP+	Health Policy Plus
HSTU	HIV/STI/Tb Unit
JADS	Jamaica Anti-Discrimination System
JaPPAIDS	Jamaica Paediatric, Perinatal and Adolescent HIV/AIDS Programme
JASL	Jamaica AIDS Support for Life
JCCM	Jamaica Country Coordinating Mechanism
JN+	Jamaica Network for Seropositives
JYAN	Jamaica Youth Advocacy Network
KAPB	Knowledge, Attitude, Practices and Behaviour
KP	Key population
LFA	Local Funding Agent
MLSS	Ministry of Labour and Social Security
MoFPS	Ministry of Finance and Public Service
MOH	Ministry of Health
MSM	Men who have Sex with Men
NBACC	New Broughton Adult Correctional Centre
NERHA	North East Regional Health Authority
NFPB	National Family Planning Board
NFM	New Funding Model
NGO	Non-Government Organization
NHF	National Health Fund
NHP	National HIV/STI Programme
NISP	National Integrated Strategic Plan
NPHL	National Public Health Laboratory

OIG	Office of the Inspector General
OGAC	Office of the Global AIDS Coordinator
OSH	Occupational Safety and Health
PAHO	Pan American Health Organization
PEPFAR	President's Emergency Plan for AIDS Relief
PCR	Polymer Chain Reaction
PCU	Project Coordinating Unit
PDSA	Plan Do Study Act
PHDP	Positive Health Dignity and Prevention
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV/AIDS
PMTCT	Prevention of Mother-To-Child Transmission
PR	Principal Recipient
PSIS	Prevention Services Information System
RFACC	Richmond Farm Adult Correctional Centre
RHA	Regional Health Authority
S&D	Stigma & Discrimination
SDC	Social Development Commission
SERHA	South East Regional Health Authority
SI	Strategic Information
STI	Sexually Transmitted Infection
SR	Sub-Recipient
SRH	Sexual and Reproductive Health
SRQ	Self Reporting Questionnaires
ST. CACC	St. Catherine Adult Correctional Centre
Tb	Tuberculosis
TCS	Treatment, Care and Support
TFACC	Tamarind Farm Adult Correctional Centre

TG	Transgender/Persons of Trans-experience
TOT	Training of Trainers
TRAT	Treatment Readiness Assessment Tool
TRP	Technical Review Panel
TSACC	Tower Street Adult Correctional Centre
TSIS	Treatment Site Information System
TWG	Technical Working Group
UBRAF	UNAIDS United Budget, Results and Accountability Framework
UIC	Unique Identifier Code
UNAIDS	Joint United Nations Programme on HIV/AIDS
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
WRHA	Western Regional Health Authority
YATWG	Youth and Adolescent Technical Working Group

MESSAGE

Dr. Christopher Tufton
Minister of Health

Jamaica is steadily pursuing actions to address key sexual and reproductive health and HIV concerns. These actions play an important role in the country's National Development Plan – Vision 2030 Jamaica, into which HIV and population and development goals and strategies have been integrated.

The Government of Jamaica (GOJ) stands behind the work of the National HIV/STI Programme (NHP) and continues to increase its budgetary contribution to match this commitment. The government hopes to reduce AIDS-related morbidity and mortality with effective biomedical and supporting interventions and reduce new HIV infections among key populations through behavioural and structural interventions. Over the year the Ministry of Health engaged available resources to advance the national response and accelerate the way for all Jamaicans to access optimum health care in respect of their sexual and reproductive rights.

Currently, of the 34,000 persons estimated to be living with HIV in Jamaica, 78% have been diagnosed and are aware of their status. The country has the highest proportion of people living who know their status in the English-speaking Caribbean—an achievement attributed to community-led prevention and testing programmes and the wide spread of provider initiated testing. Programme data indicate that 75% of persons diagnosed have been linked to care, and of those linked, 62% have been retained in care.

In 2017, Jamaica adopted the WHO 2015 "Treat All" guidelines, which contain key recommendations to treat all people living with HIV, including children, adolescents, adults, pregnant and breastfeeding women and people with coinfections. The guidelines are based on findings noted in several studies which showed a reduction in morbidity and mortality if treatment was started at diagnosis. Towards this end, a social-marketing campaign was launched by the Ministry of Health to encourage persons living with HIV to take their medication and to continue to do so for life. The campaign, which is dubbed, 'Test and Start: Get on yu meds and get on wid life', goes further to encourage persons to get tested for HIV to know their status, and if confirmed positive, to commence antiretroviral treatment. Radio, television and poster advertisements form part of the social-marketing campaign of 'Test and Start'.

Testing is a critical tool in the management and treatment of HIV/AIDS. The national

programme made more progress with the initiation of HIV prevention among key populations through the outreach strategy. During 2017, 10,693 men who have sex with men (MSM) were reached and 5,759 were tested while 6,694 out of the 10,230 female sex workers (FSW) reached were tested. The challenges to reach persons of trans-experience (TG) persists, however 654 were reached and 361 tested. A total of 1,858 inmates across seven adult correctional institutions were reached and tested for HIV and Syphilis.

Investments in the national AIDS response continue to generate concrete results. Key achievements in 2017 include the launch of the rebranded Jamaica Anti-Discrimination System for HIV (JADS), which is a robust and confidential mechanism through which people living with HIV, and other persons who experience stigma and discrimination at health institutions, can make reports and seek redress.

The target for the rate of mother-to-child transmission of HIV was not met for the year. This is a national priority issue. Several strategies are being pursued by the Ministry of Health to get the country back on track to secure and sustain elimination status. The Programme also faces other serious challenges. Gaps in the continuum of care continue to pose a problem especially in the areas of linkage and retention in care, ARV coverage and viral suppression. This is especially so for youths and other key populations.

Nevertheless, our commitment as a country to end the AIDS epidemic by 2030 as a legacy to present and future generations, to accelerate and scale up the fight against HIV and end AIDS to reach this target, and to seize the new opportunities provided by the 2030 Agenda for Sustainable Development, remains strong. We will do more to ensure that no one is left behind. Improvements in the health information system will be undertaken to better guide the national response. New ways must be found to reach and link MSM and other key populations, as well as to combat internal and external stigma. Stopping new HIV infections and untimely HIV-related deaths through both primary and secondary prevention and better management approaches must be prioritized.

MESSAGE

Sancia Templer
Permanent Secretary

The prevention and management of HIV, Sexually Transmitted Infections and Tuberculosis remains one of the Ministry of Health's top priorities. The Ministry plays a critical role in the management and distribution of resources to support the National HIV Programme. The response is financed primarily through the Government of Jamaica and contributions from the Global Fund to Fight AIDS, Tuberculosis and Malaria and the United States Agency for International Development. Together these funds support activities and interventions that target key populations and people living with HIV (PHLIV), as directed through the various components of the response including Prevention, Treatment, Care and Support services, Enabling Environment and Human Rights, Monitoring and Evaluation and Governance and Programme Management. The MOH has contracted a total of twenty-one (21) implementing partners under the Global Fund and PEPFAR/USAID grants, ten (10) of which receive funds from both grants to implement activities in the response to HIV.

Jamaica has made some strides in its commitment to "treat all" people living with HIV as a treatment and prevention strategy. The "Treat All" strategy by the WHO in 2015 aims to improve the quality of HIV treatment and to bring us closer to the universal health coverage ideals of integrated services, community-centred and community-led health care approaches, and shared responsibility for effective programme delivery. All geared to end AIDS by 2030. With this move, however, there was a clear recognition of the need to invest in strategic information to guide programme planning and sustain national and international commitment and accountability. Strategic information is essential if the National HIV/STI Programme is to respond proactively to the epidemic. Toward this end, the monitoring and evaluation component of the programme was restructured during the year to form the strategic information (SI) component. The SI component is responsible for undertaking surveillance of HIV and sexual transmitted infections (STIs), monitoring and evaluation and research to guide policy, planning, resource allocation, programme management, service delivery and accountability.

The focus on youth continued during 2017. One significant development was the continued operation of a 'Teen Hub' at the Half Way Tree Transport Centre, in St. Andrew, for adolescents and youths to access a mix of services. The services include counselling, HIV and Syphilis testing and mental health screening. A total of 2,665 young people

visited the Teen Hub in 2017 and 657 HIV tests were conducted. This has strengthened our commitment to providing increased access to sexual and reproductive health services for young people, including valuable information about preventing HIV and STIs.

Bolstered by partnerships with Government Ministries, Departments and Agencies, private financial institutions, non-governmental organization and community-based organizations, the Prevention component of the programme continued with some key intervention strategies during the year, including risk assessment and risk reduction conversations, psycho-educational sessions, evidence-based interventions and voluntary counselling and testing (VCT). We continue to see marked declines in HIV prevalence among female sex workers of 2% coming from as high as 12% in the early 1990s.

Work continued in 2017 to advance care, treatment and support for the estimated 34,000 individuals living with HIV in Jamaica. The data indicates that significant achievements have been made in core areas of the treatment priority area such as diagnosing 78% of persons estimated to be living with HIV. Despite the lingering gaps in linkage to care, retention in care and viral load suppression there are incremental improvements in the number of persons returned to care.

For Jamaica, the way forward to achieving the global HIV goals requires continued sustained effort. All stakeholders in the response must do more strategically. The Ministry of Health is committed to its role to provide national leadership for HIV prevention, treatment, care and support. More focus will be given to HIV primary prevention and the promotion and provision of effective tools to prevent HIV infections while addressing the gaps in human resources, health information and the enabling environment and human rights.

MESSAGE

Dr. Nicola Skyers
Senior Medical Officer, HIV/STI/Tb Unit

The advances made, and the lessons learnt, in the treatment and prevention of HIV/AIDS during the year would not have been possible without the strong participation of all the partners and stakeholders in the national HIV response. The focus given to increasing the scale and quality of implementation of HIV prevention programmes has resulted in an estimated 78% of PLHIV being aware of their status and 95% of the persons living with HIV in care, retained on antiretroviral therapy.

There were no ARV stock outs in 2017. An ARV tracking tool was developed to record quantities of ARVs and Test kits in stock at the National Health Fund (NHF) warehouse. This tool has allowed the easy visualization and early identification of ARV levels allowing timely ordering and delivery lead times. Notably, during the year, ARVs were procured through the Global Fund pooled procurement mechanism (WAMBO) process, and although there were some minor challenges using the platform and delays with delivery, the overall procurement time frame remains shorter than the standard GOJ process. Of significance too is the fact that the NHF assumed the management of government pharmacies in 2017. This change will lead to a standardized management structure, which is expected to result in improved tracking of the dispensing of ARVs.

In 2017 a lot of emphasis was placed on building the capacity of the psychosocial team and standardizing practice and documentation systems across the four Regional Health Authorities (RHAs). A training curriculum for case managers was developed and successfully piloted. Also completed was the Adherence Counsellors' protocol, which will guide the standardization of adherence counselling practice across RHAs.

HIV testing is normalised with high demand from both key and general populations. However, persons who are at high risk of contracting HIV continue to be reluctant to access the service. During the year, the Prevention team was challenged to develop differentiated prevention packages that meet the need of key populations and the general population. The Peer Navigation system, which involves linking PHLIV to health care systems, identifying and reducing barriers to care, and tailoring health education to the client to influence his or her health-related attitudes and behaviours, was officially rolled

out in 2017. Prior to the rollout 120 Peer Navigators were trained, certified and deployed.

In 2018, the Programme will incorporate the following:

- A quality assurance plan will be implemented to aid in ensuring the quality of ARV drugs obtained through the WAMBO process.
- Health care workers will be trained to identify and handle cases of gender based violence.
- The HIV/AIDS Tracking System (HATS), which has been a repository for all diagnosed cases in the Jamaica since the start of the epidemic, will be merged with the Treatment Site Information System (TSIS). This will allow for a seamless monitoring of the epidemic.
- Formulation of an overarching roadmap for STIs in Jamaica that considers the current state of affairs, implements recommendations from the 2017 SITAN and determines the most feasible approach for the continued holistic management of STIs.

The mandate of the HIV/STI/Tb Unit to support the provision of quality services to those at risk of, infected with, and affected by HIV, remains unchanged. We will go forward into 2018 with an even greater commitment to accelerating prevention, treatment, care and support for those most at risk.

MESSAGE

Lovette Byfield
Executive Director, National Family Planning Board

Jamaica welcomes the opportunity to be at the forefront of that forward-thinking movement to transform our world and our country to ensure sustainable development by 2030. Our people deserve to attain good health and well-being, no poverty, zero hunger, gender equality, reduced inequalities and opportunities for quality education, a clean environment, decent work and economic growth. These are some of the seventeen (17) sustainable development goals articulated by the United Nations. The accelerated success of our national sexual and reproductive health (SRH) and HIV programmes will contribute significantly to the achievement of those goals and will ensure that indeed, no one is left behind. The realisation that population explosion places pressure on the availability of resources of a natural, national and familial kind, and influences prospects for work and earning potential, highlights the need to institute control measures.

Health care providers are conduits for the messages and services provided by the National Family Planning Board and the Ministry of Health. The focus on the SRH and HIV work of public sector health care workers and civil society partner organisations was borne out in the Mid-term Evaluation of the National Integrated Strategic Plan for Sexual and Reproductive Health and HIV, 2014-2019, in November 2017. Admittedly there are still challenges to be overcome by the National HIV/STI Programme for the real benefits to be realised by persons of reproductive age including adolescents, PLHIV, key and vulnerable populations and by extension their loved ones and the wider society. There is a clear need for improvement in the attitudes of some health care workers and their treatment of clients. Additionally, the stigma and discrimination portrayed by ancillary workers to adolescents and key populations must be erased from the landscape.

Kudos for the expansion of testing, treatment and care services, which were underpinned by strong partnerships, effective coordination and utilization of resources and a high quality training programme.

Getting to sustainability revolves around behaviour change. Behaviour change where safe sexual practices becomes normative, HIV/STI testing is accessible to all and individuals started on antiretroviral/HIV treatment adhere to the regimen and can lead productive

lives that contribute to the nation's growth.

By way of this Annual Report the HIV programme is giving account of our duty bearers. From the point of the strategic priorities, the NFPB's core areas of contribution to the national programme and this report are in:

- Prevention and Sexual and Reproductive Health Outreach
- Enabling Environment and Human Rights
- Monitoring and Evaluation
- Sustainability, Governance and Leadership

The workers of the NFPB recommit their energies to the people of Jamaica and thank the Government of Jamaica and our international development partners for their investments in the National HIV/STI Programme.

FOREWORD

Jamaica continues to make progress in scaling up prevention programmes as part of a comprehensive national response to meet global targets and commitments to end AIDS as a public health threat by 2030. Critical to this effort has been the commitment and support of the Government of Jamaica, donors and international partners and civil society.

The national HIV/STI response is funded primarily by the Government of Jamaica, the Global Fund to Fight AIDS, Tuberculosis and Malaria and the United States Agency for International Development; the budgetary contribution for 2017 was J$1.95B. The GOJ was the leading contributor by a slight margin; contributing J$765.38M (39%) through the recurrent budget and through its contribution towards the USAID and Global Fund grant funded projects. The Global Fund contributed J$762.31M while USAID contributed US$3.1M. The Programme also received J$0.11M in small grants from UNICEF.

The National HIV/STI Programme is executed through the combined efforts of the HIV/STI/Tb Unit (HSTU) and the National Family Planning Board – Sexual Health Authority along with key partners and stakeholders in the national response. The National HIV response is led by four technical components: Prevention and Health Promotion; Treatment, Care and Support (TCS); Enabling Environment and Human Rights (EEHR) and Strategic Information. During the year, several new initiatives were undertaken to accelerate the HIV response. A few of these are highlighted below and are further elucidated in this annual report.

Surveillance data estimates that there are 34,000 persons living with HIV in Jamaica in 2017 up from 30,000 in 2016. The number of newly reported HIV cases declined from 2,015 cases in 2016 to 1,197 cases in 2017; some 7% were reported notified for the first time as deaths. HIV prevalence among the general population is estimated at 1.8% up from 1.7% in 2016.

Several studies were undertaken during the year and will form the basis for the work ensuing in 2018 and beyond. These include:

- Bio-Behavioural Surveillance Survey of Female Sex Workers
- Bio-Behavioural Surveillance Survey of Men who have Sex with Men
- Annual HIV Sentinel Surveillance Sero-survey
- Knowledge, Attitude, Behaviour and Practice (KABP) Survey

SEX WORKER SURVEY

The FSW Survey was conducted among Female Sex Workers, Female Patrons and Workers of Sites where Persons Meet Sex Partners or Participate in Sexual Activity in Jamaica. The prevalence of HIV among female sex workers seems to be continuing its steady decline down from 4.1% in 2011 and 2.9% in 2014 to 2% in 2017. Workers and patrons at sites where female sex workers operate also exchange sex for money and need to receive similar

interventions as sex workers. The study also showed that partner/ relationship intimacy is the biggest threat to consistent condom use.

MSM SURVEY

Data collection for the *Integrated Biological and Behavioural Surveillance Survey with Population Size Estimation among Men who have Sex with Men and Transgender Persons in Jamaica* began in December 2017. The study will be used to estimate the size of the MSM and Transgender (TG) populations and to determine HIV prevalence and risk behaviours for these groups.

SENTINEL SURVEY AMONG ANC ATTENDEES AND STI CLINIC ATTENDEES

The Annual HIV Sentinel Surveillance Sero-survey was conducted in sentinel sites from three urban parishes and three rural parishes from all four health regions. Certain trends were observed in the HIV seroprevalence of various sub-groups of study participants of the 2017 HIV Sentinel Surveillance Serosurvey; many of these are consistent with what has been noted over the years that the survey has been in existence.

Higher prevalence of HIV was observed in STI clinic clients (4.6%) compared to antenatal clinic (ANC) clients (0.9%); in both groups the 2017 HIV seroprevalence rate was an increase over the previous year. Generally, the male cohort of participants had a higher prevalence than the female cohort. A higher HIV prevalence was observed in the urban cohort compared to their rural counterparts for both ANC clients and STI clinic clients. The trends in ANC client HIV seroprevalences over the years would indicate that there has been a downward trend in the epidemic since the mid-1990s and that the rate has stabilized since 2010 (up until 2017). These findings are similar to what has been reported from surveillance data. The HIV seroprevalence in STI clinic clients has also trended downwards since the mid-1990s. However, the rate in the last three years (2014 to 2017) has shown an upward trend. The 2017 prevalence is similar to the 2004 rate.

Syphilis seroprevalence was higher than HIV seroprevalence for both ANC (0.96%) and STI (6.1%) clinic clients. Males overall had a higher Syphilis sero-prevalence than females, and rural dwellers had a higher rate than urban dwellers (for both ANC and STI clinic cohorts). Syphilis positive clients had a higher HIV seroprevalence (15.4%) than both the general ANC (0.9%) and STI clinic client (4.6%) survey populations.

KNOWLEDGE, ATTITUDES, PRACTICES AND BEHAVIOUR SURVEY

The KAPB is a cross-sectional, household-based survey that was conducted among a randomly selected a sample of 2,000 persons island-wide. The results of the 2017 KAPB indicate mixed programme results in several areas.

Fewer persons are initiating sex early; the median age for first sex is maintained at age 15 years for males and age 17 years for females as obtained in the 2012 survey. There is notable improvement among the males, aged 15-24, who have had sexual intercourse before the

age of 15 (from 49% in 2012 to 41.6% in 2017); no change is recorded among the females. This improvement in early sexual debut is also reflected in more persons 15-19 who report having never had sex. Multiple partner relationships, which ranks among the leading risk factors in Jamaica, increased marginally in 2017 versus 2012; most notable within the age subgroups was an increase among the 15-24 years male cohort. Overall, condom use at last sex act among persons reporting multiple partners declined from 61.1% in 2012 to 58.7% in 2017. The percentage of adults aged 15–49 reporting transactional sex declined significantly in 2017 (31%) versus 2012 (39%). This decline was evidenced in both genders as well as in age and relationship status. The proportion of persons expressing accepting attitudes towards people with HIV/AIDS declined significantly in 2017 (11.6%) versus 2012 (14.3%). Intimate partner violence against married or partnered women was considerably more prevalent in 2017 with 14.8% of women reporting same versus 9.3% in 2012; this was notably so for women younger than 25 years. Overall there was a decline in correct knowledge of HIV transmission from 38.5% in 2012 to 32.9% in 2017 among both males and females but more so among females.

This 2017 report presents information on the HIV response between January 1 and December 31, 2017. It describes the trends in the epidemic in Jamaica, the programmatic activities geared at prevention, care and treatment and actions at policy and legislative reform.

EXECUTIVE SUMMARY

OVERVIEW

At the end of 2017, 34,000 Jamaicans were estimated to be living with HIV. Since 1982, 36,553 Jamaicans were diagnosed with HIV, the majority (72%) of whom 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 1.8%, however surveys show a 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. Estimates among KPs show that the prevalence rate is approximately 32%, 2% and 52% among MSM, FSW and people of trans-experience, respectively.

In 2017, 1,197 newly diagnosed cases were reported to the MOH. Of this, 7% (82) were reported to the National Epidemiology Unit for the first time as deaths. This indicates that there is still need for wider testing.

Persons aged 20-29 years accounted for the largest proportion (26%) of newly diagnosed cases in 2017 followed by persons aged 30-39 years old who accounted for 24% of the total reported cases.

Just under a third (32%) of Jamaicans living with HIV are aged 20-29 years old. More than half (61%) of Jamaicans living with HIV currently reside in the most urbanized parishes, namely Kingston and St. Andrew, St. Catherine and St. James.

STRATEGIC INVESTMENTS IN THE FIGHT AGAINST HIV/AIDS

The objectives of the National HIV/STI/Tb Programme are primarily guided by the National Integrated Strategic Plan for SRH and HIV and specific objectives of Vision 2030 Jamaica, the National Development Plan. A substantial portion of the funding for the HIV/AIDS response has been supported through agreements with donor agencies such as the Global Fund New Funding Mechanism and the United States Agency for International Development. However, contributions from the Government of Jamaica have increased significantly since 2013. This signals a strong commitment to a more sustainable national response.

The budgetary contribution for the HIV/AIDS response in 2017 was J$1.95B; this represents an approximately 16% (J$269M) increase over the previous year. The total GOJ contributions through the recurrent budget and through its contribution towards the USAID & Global Fund grant funded projects, was J$765.38M. The GOJ's contributions increased by 19% (J$118.84M) in 2017 making the GOJ the largest overall contributor by a slight margin over the Global Fund. Resources were also received from the GOJ through in-kind contributions.

The Global Fund New Funding Mechanism (NFM), signed in 2016, was in the second year of implementation and contributed 39% of the budget (J$762.31M), which is an increase of approximately 21% over the previous year. Under USAID, the Year 7 agreement was signed in the amount of US$3.1M; this grant is expected to end in September 2018. Operating concurrently during 2017 was Year 6 Implementation Letter (IL) 4; this grant had an originally end date of September 2017, however, it was extended to March 2018. The Programme also received J$0.11M in small grants from UNICEF.

STRENGTHENING THE APPROACH TO FIGHTING HIV/AIDS

The NHP expanded its outreach to all PHLIV.

Jamaica adopted the WHO 2015 "Treat All" guidelines, which contain key recommendations to treat all people living with HIV, including children, adolescents, adults, pregnant and breastfeeding women and people with coinfections. The guidelines are based on findings noted in several studies which showed a reduction in morbidity and mortality if treatment was started at diagnosis.

The NHP made a significant step to strengthen the data system.

The Monitoring and Evaluation Component was given a bigger mandate and reformed into the Strategic Information (SI) Component. As the overarching goal to end the HIV epidemic emerged and the work of the HIV/STI/Tb Unit expanded, the need for a more comprehensive approach to data capture, analysis and use became increasingly critical. There was a clear need for strategic information that exceeded the boundaries of monitoring and evaluation to include surveillance, research and health information systems.

The SI Unit collects, analyses and disseminates data that is used to evaluate and expand the efficiency and appropriateness of programmes, which are aimed at prevention of HIV transmission, early detection of new HIV infections and treatment of HIV infected individuals. The National HIV/STI Programme relies on the SI component to shape its objectives, inform and improve strategy and programming and monitor progress through research, analysis and forecasting. Programme Managers, policy-makers and stakeholders rely on quality information to make informed decisions that are in the best interest of the people and groups they serve. The SI component enables the HIV/STI Programme to respond proactively to the epidemic.

The NHP expanded its work in the Enabling Environment and Human Rights arena.

A legal and policy review committee was established to coordinate the development of policy positions, use of findings from previous legal reviews, compilation of best practices and production of other communications to inform and guide SRH Advocacy Strategy. The Enabling Environment & Human Rights Unit convened six (6) legal and policy review committee meetings and two (2) dissemination meetings to coordinate the development, printing and dissemination of policy positions and legal briefs. The Committee comprises

representatives from key Government Ministries, Departments and Agencies, civil society organisations (CSOs) and international development partners. The committee will function to build consensus among sexual and reproductive health stakeholders and partners on recommended actions to address gaps in programming and the policy and legislative frameworks for HIV and SRH in Jamaica. Two policy briefs were drafted and endorsed by the Committee on the topics of HIV Sensitive Social Protection and Recommendations to address discrimination based on health status with focus on HIV and SRH needs.

KEY ACHIEVEMENTS IN THE FIGHT AGAINST HIV/AIDS

Improvement in the management and distribution of ARVs

There were no ARV stock outs in 2017. A constant supply of ARVs is essential to support the new initiative to "Treat All". In response to the challenges experienced with ARV stock levels in 2016, changes were made in the forecasting and planning mechanisms to prevent national stock outs of ARVs. Training was carried out with members of the TCS and SI Unit on the Quantimed and Pipeline software, which assists with the forecasting of ARV needs and allows planned ordering of ARVs. Additionally, an ARV tracking tool was developed by the Treatment, Care and Support unit to record quantities of ARVs and test kits in stock at the National Health Fund warehouse. The tool details the average monthly usage of the ARVs, expected deliveries of ARVs, expiry dates, expected duration of ARVs in stock and the expected duration of ARVs with upcoming deliveries. The tool has allowed the easy visualization and early identification of ARV levels allowing timely ordering and delivery lead times. Increased collaboration with the NHF warehouse team has also been initiated.

Additionally, although delays in receiving some of the shipments of ARV orders procured through WAMBO resulted in a stock out of ARVs at some treatment sites, recirculation of ARVs between ARV dispensing pharmacies minimized the interruption of patient treatment and prevented patients from being switched to alternate regimens.

Notably, the National Health Fund assumed the management of all government pharmacies in 2017. This change will lead to a standardized management structure, which is expected to result in an improvement in the number of ARV dispensing pharmacies that submit Pharmacy reports.

Improvement in Procurement Efficiency

The introduction of the E-Procurement System, the Government of Jamaica's first electronic procurement platform, and its establishment of the new Specialist Sector Committees to facilitate the timely processing of submissions for awarding contracts has significantly improved the HSTU's ability to carry out its procurement functions. Some 2,000 persons, including procurement practitioners and suppliers, were trained to use the E-Procurement System in 2017. The HSTU utilized the Goods Specialist Sector Committee in 2017 to receive approval for the procurement of Viral Load Tests, Reagents and Supplies valuing over JMD 60M, with notable success. The HSTU had access to specific persons on the Committee, which made for easier communication and faster processing time.

Closing the Gaps in the Continuum of Care

During 2017, the deployment of PHLIV as lay providers was piloted as an approach to involve PLHIV in the delivery of HIV and SRH services. The engagement of PHLIV Facilitators initiated the formal inclusion of PLHIV participation as lay providers in health systems. The engagement of PLHIV Facilitators to provide one-on-one support to their peers at the treatment sites and work as members of the treatment team is one innovation that has the potential to increase the number of clients who adhere to their treatment and eventually become virally suppressed.

The use of the case management approach has helped the workers at the treatment sites to work better as a team. During the year, treatment teams engaged a collaborative approach to reviewing, assessing, facilitating and coordinating care for each client resulting in the best suited treatment team member(s) being assigned to guide and assist individual PLHIV cases. The scale-up of the case management approach, to ensure that clients receive quality services and care from entrance to exit of the health facilities, will accelerate the national response.

In 2017, the implementation of the Treatment Site Mentoring Team to conduct audits, provide recommendations on corrective measures and provide technical support to the treatment team was helpful in addressing some critical gaps at the site level. The work of the Treatment Site Mentoring Team will be scaled up to ensure that corrective measures are implemented in a timely manner and that improvements are properly documented.

The Peer Navigation System was officially rolled out in January 2017 following the training, certification and deployment of 120 Navigators in 2016. Navigation includes linking persons to health care systems, identifying and reducing barriers to care and tailoring health education to the client to influence his or her health-related attitudes and behaviours. The Peer Navigation System has facilitated the link between HIV prevention and treatment. Efforts to scale-up the Peer Navigation System will involve the participation of Navigators in treatment team meetings and training in the case management approach.

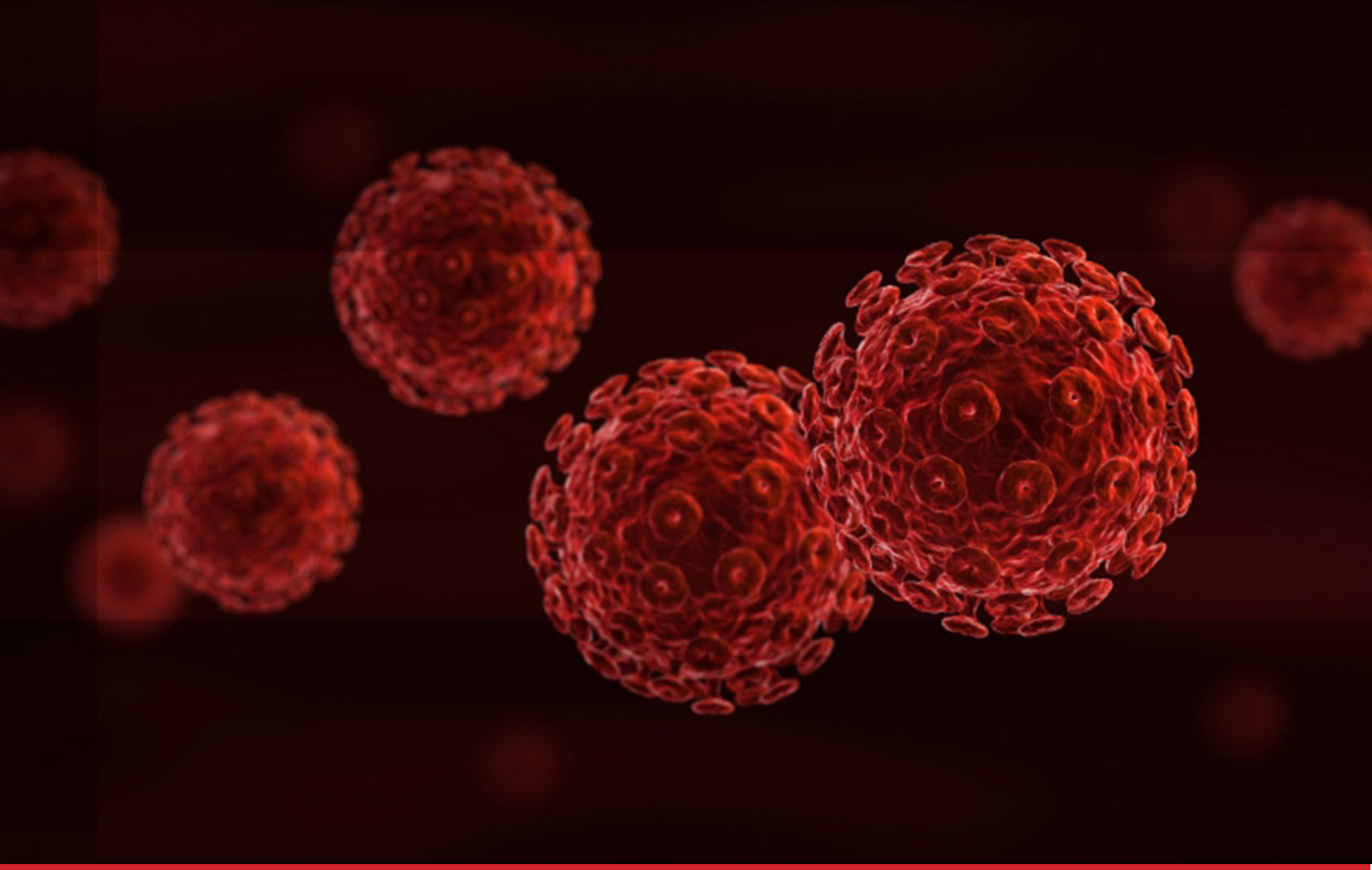
CONCLUSION

During the reporting period, the NHP made strides in addressing the HIV/AIDS epidemic in Jamaica and was able to build on the foundation that it had established in previous years. During the year, the NHP expanded its programming by using information gathered through surveillance and research; strengthened its ability to use data to drive its response to the epidemic and continued its efforts to engage and empower stakeholders to ensure that the national response remains relevant.

The work of the NHP continues in the face of challenges in reaching key populations. It has become more difficult to engage FSWs in site-based interventions as more of them work from home and use their phones to contact their clients. For the MSM and TG population, the lack of safe spaces and stigma within the community continue to hinder the progress

of intervention. The refusal of some inmates to do blood work, the transfer of inmates between correctional institutions without their medical charts, the "no-condoms in prison" policy and delays in results from the National Public Health Laboratory have all created challenges for follow-up and care in the correctional system.

Nevertheless, the NHP through the GOJ and its partners in the response will continue the work towards control of the HIV and AIDS epidemic in Jamaica, buoyed by the momentum of the progress made over the last six years.

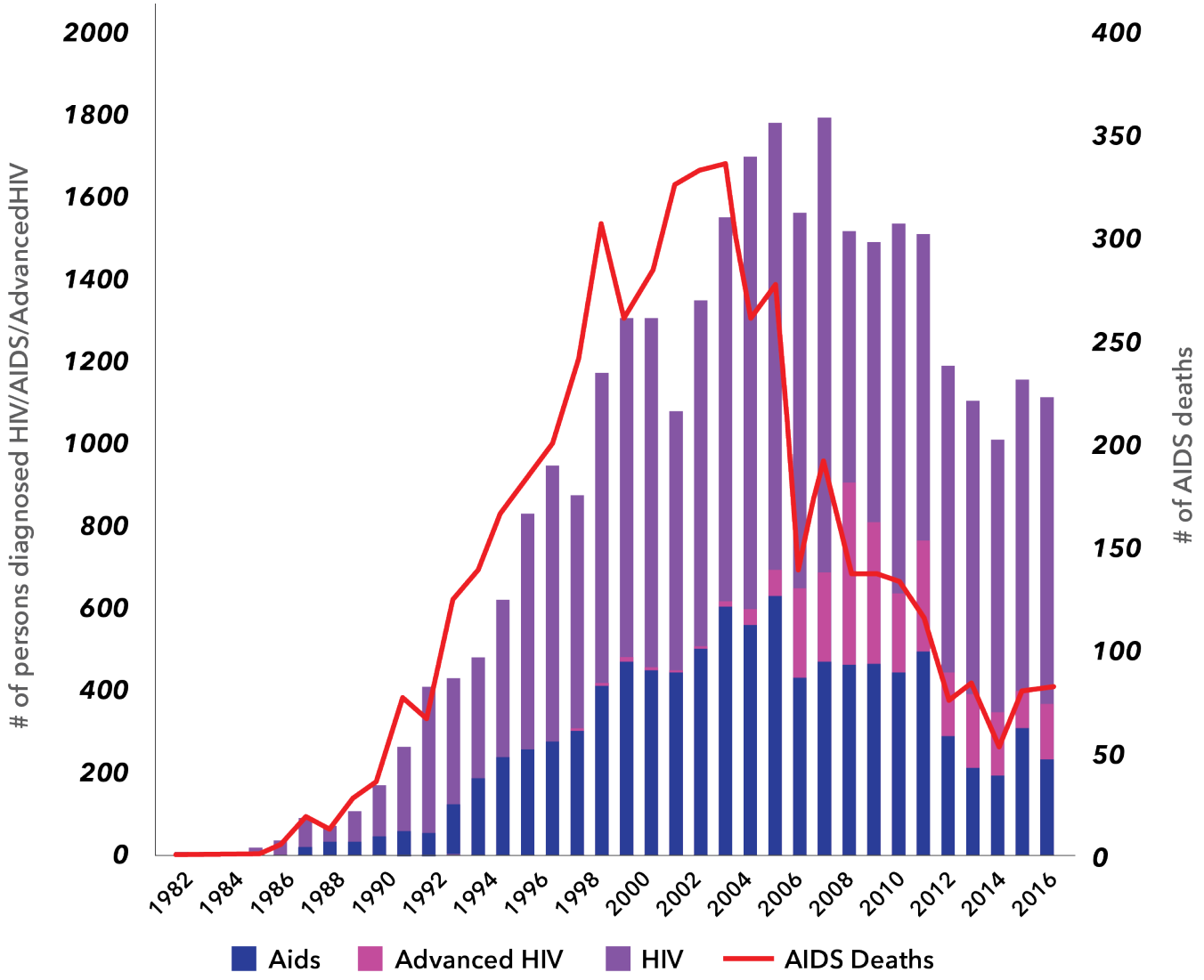


CHAPTER 1: EPIDEMIOLOGY OF HIV IN JAMAICA

The Ministry of Health's 2017 HIV Epidemiology Profile indicates that an estimated 34,000 persons are currently living with HIV, but approximately 22% are unaware of their status.

In 2017, there were 1,197 newly diagnosed cases, a significant decline from the 2,015 cases reported in 2016.

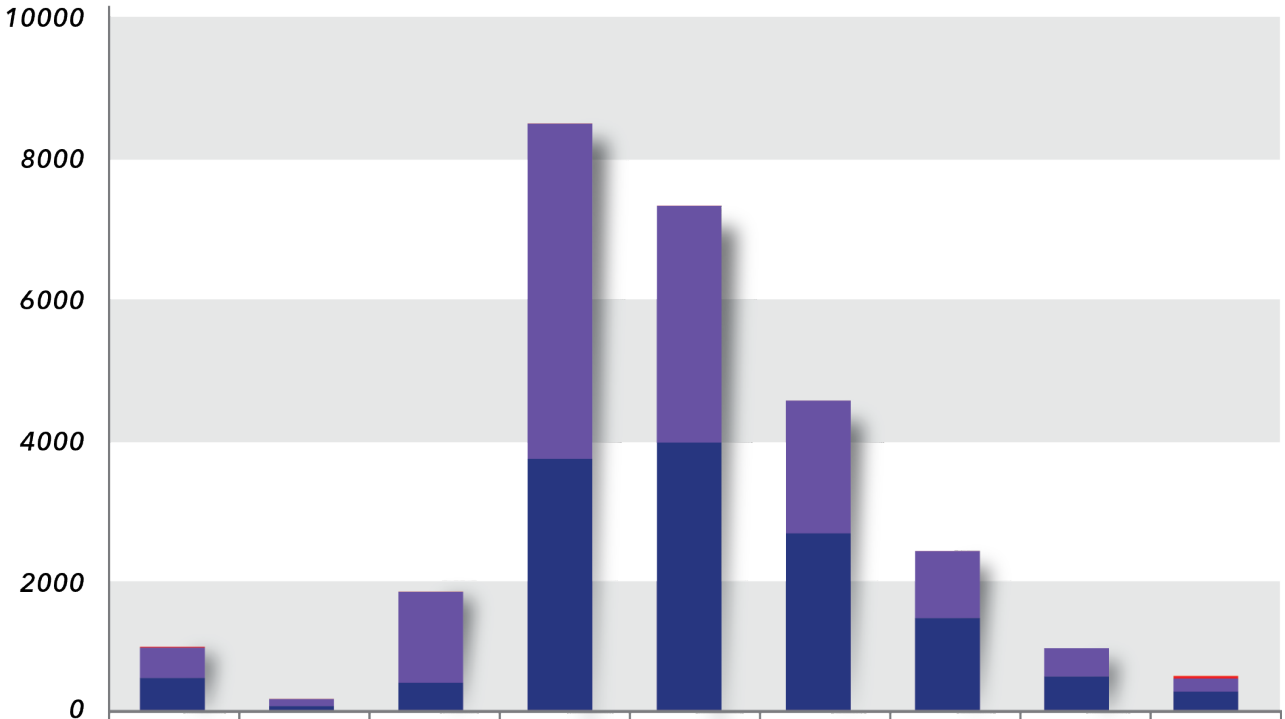
Fig. 1 Persons Living with HIV (non-AIDS), Advanced HIV and AIDS and Deaths in Jamaica, 1982-2017



AIDS MORTALITY

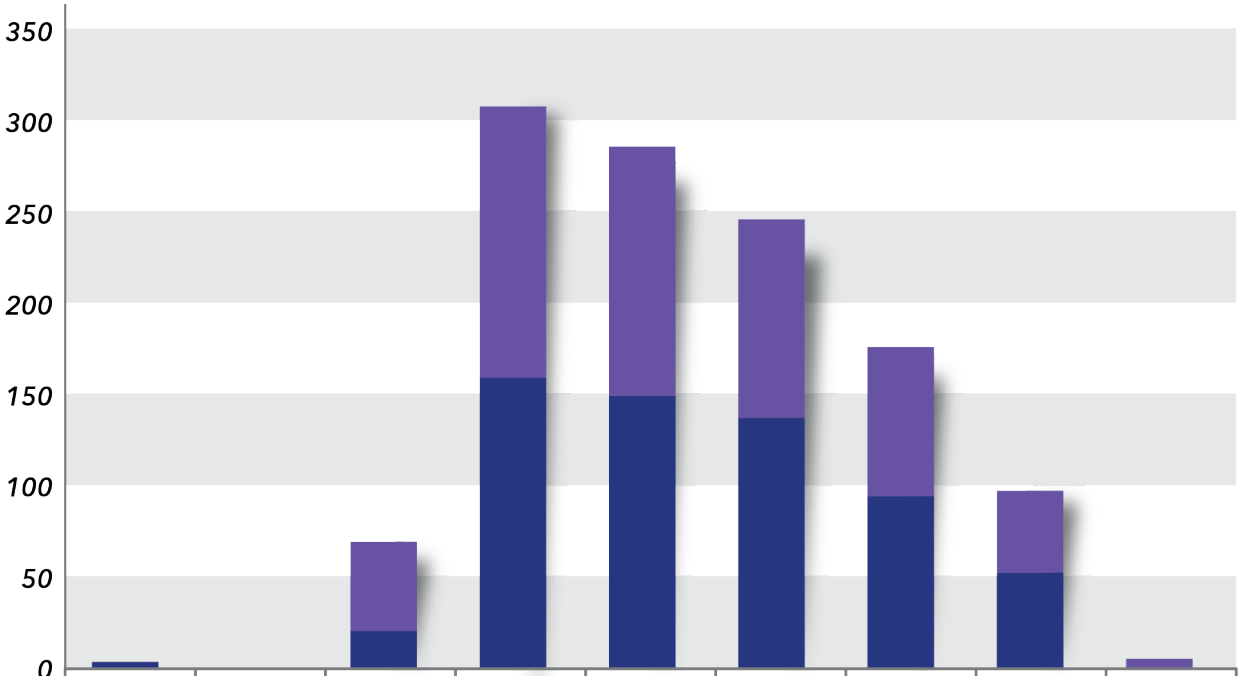
Jamaica continues to produce good results in terms of the number deaths averted because of AIDS-related illnesses. The AIDS mortality rate declined from 25 deaths/100,000 population in 2004, to just over 10 deaths/100,000 population in 2017; this represents a significant decline since the inception of 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 Voluntary Counselling and Testing (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.

Fig. 2 Number of people living with HIV/AIDS by Sex & Age (Current)



	0 to 4 years	5 to 9 years	10 to19 years	20 to 29 years	30 to39 years	40 to 49 years	50 to 59 years	60 years and older	Unknown
Unknown	***15***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***37***
Female	***427***	***100***	***1288***	***4747***	***3353***	***1881***	***952***	***400***	***184***
Male	***481***	***81***	***413***	***3582***	***3813***	***2557***	***1327***	***501***	***287***

Fig. 3 New HIV, Advanced HIV and AIDS in Jamaica by Sex & Current Age (2017)



	0 to 4 years	5 to 9 years	10 to 19 years	20 to 29 years	30 to 39 years	40 to 49 years	50 to 59 years	60 years and over	Unknown
Unknown	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***
Female	***0***	***0***	***49***	***149***	***137***	***109***	***82***	***45***	***5***
Male	***4***	***0***	***21***	***160***	***150***	***138***	***95***	***53***	***0***

NEWLY DIAGNOSED CASES

In 2017, 1,197 newly diagnosed cases were reported to the MOH. Approximately 62% 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 82 (7%) of these cases were still notified to the National Epidemiology Unit for the first time as deaths. Persons aged 20-29 years accounted for the largest proportion (26%) of newly diagnosed cases followed by those aged 30-39 years old accounting for 24% of the total reported cases.

Fig. 4 First Reported & Classified 2017

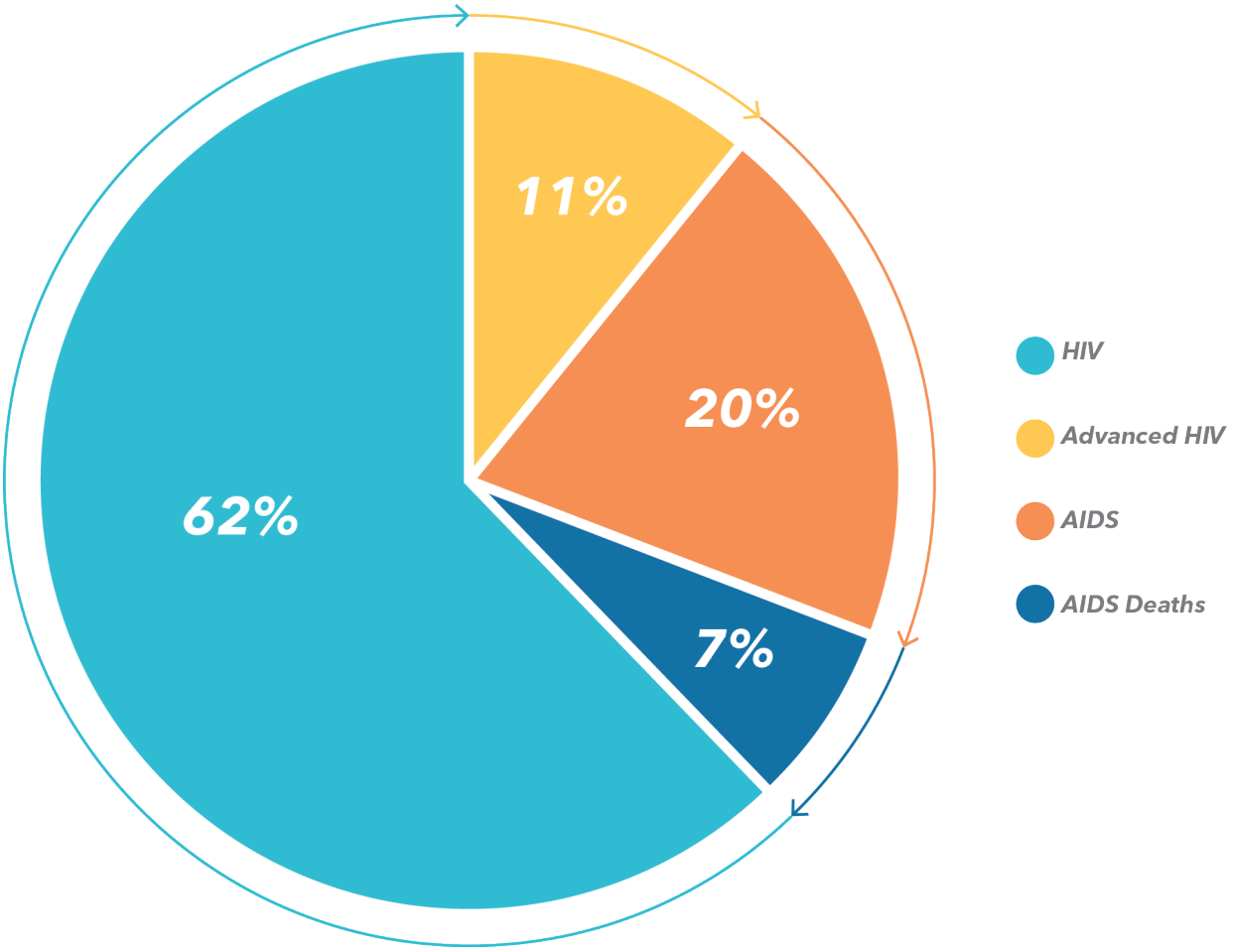
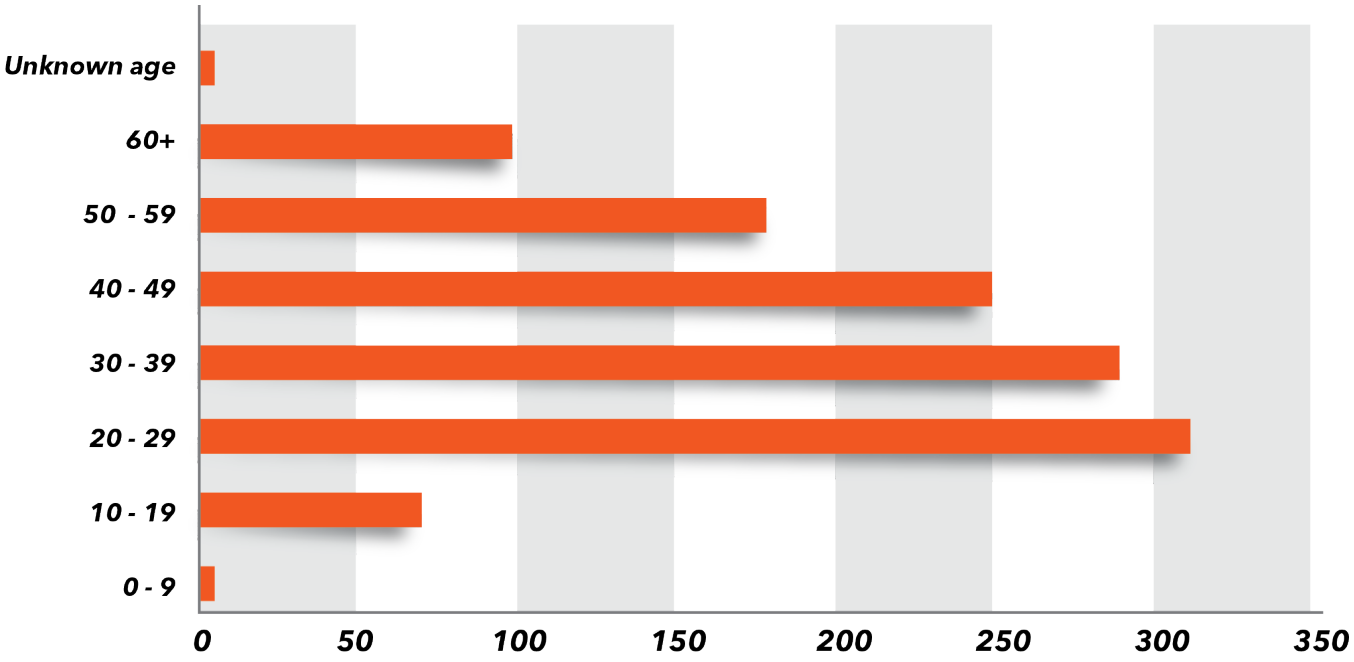


Fig. 5 First Reported by Age Group 2017



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 1.8%, however survey show higher HIV prevalence in at-risk groups.

The main risk factors fuelling the epidemic in Jamaica include history of STIs, men having sex wth men, multiple sex partners, and sex with sex workers.

CHAPTER 2: HEALTH PROMOTION AND PREVENTION

OVERVIEW

The prevention of HIV and AIDS is a key component of the National HIV/STI Programme. This component focuses on developing, promoting and supporting health promotion and behaviour change strategies that impact sexual risk behaviours and cultural norms to reduce the transmission of HIV and other sexually transmitted infections (STIs). Behaviour Change Communication (BCC) is used to guide the development of strategies to reduce the transmission of new HIV infections through universal access t o prevention and support services, among general as well as key populations. This work is led by the National Family Planning Board in collaboration with the Prevention teams from the four Regional Health Authorities as well as several civil society organizations (Jamaica AIDS Support for Life, ASHE, Children First, Children of Faith and National Council on Drug Abuse).

In 2017, the Prevention Unit pursued five (5) broad objectives including: identifying, building relationships and increasing interactions with MSM and TG populations; maintaining reach and coverage of all known sex work sites; providing opportunities for HIV testing during community outreach activities using the mobile testing unit, with increased focus on the key populations; reducing new HIV infections especially among 15-49 age group and improving the treatment cascades through Peer Navigation.

During the year, specific effort was made to target KPs that are considered most at risk, including men who have sex with men, female sex workers, persons of trans-experience and vulnerable populations like inmates of correctional facilities (both males and females). The current HIV prevalence rate for the general population is 1.8% while estimates among KPs show that the prevalence rate is approximately 32%, 2% and 52% among MSMs, FSWs and TGs, respectively (MOH EPI data 2017). Key populations were targeted at three levels: individual, group and community. The intervention strategies included: risk assessment and risk reduction conversations; capacity building; psycho-educational sessions; evidence-based interventions and voluntary counselling and testing.

Some of the key messages that were delivered through the work of the Prevention Unit include:

- Abstinence
- Delay debut of sexual activity
- Reduce multiple partnerships
- Mutual monogamy
- Access rapid HIV and Syphilis testing
- Practice treatment seeking behaviour
- Consistent and correct condom use and condom negotiation
- Utilize referrals for treatment, care and support

The efforts of the Prevention Unit were bolstered by partnerships with other entities such as Government Ministries, Departments and Agencies, private financial Institutions, non-government organizations (NGO) and community-based organizations (CBOs). The partnerships were valuable in addressing some of the social, economic, political and cultural challenges that would have impacted implementation, and ultimately the achievement of Programme targets.

OUTREACH TESTING

HIV testing is normalised with high demand from both key and general population. However, persons who are at high risk of contracting HIV, especially within the communities, continue to be reluctant to access the service. During the year, the Prevention team was challenged to devise creative and innovative strategies for promoting testing and increasing uptake. It became necessary to increase conversations and testing opportunities among the general population to unearth the key populations who would not be reached through the targeted testing.

In addition to conducting routine HIV and Syphilis testing, site based prevention interventions are a key element of the Prevention package of services. These interventions

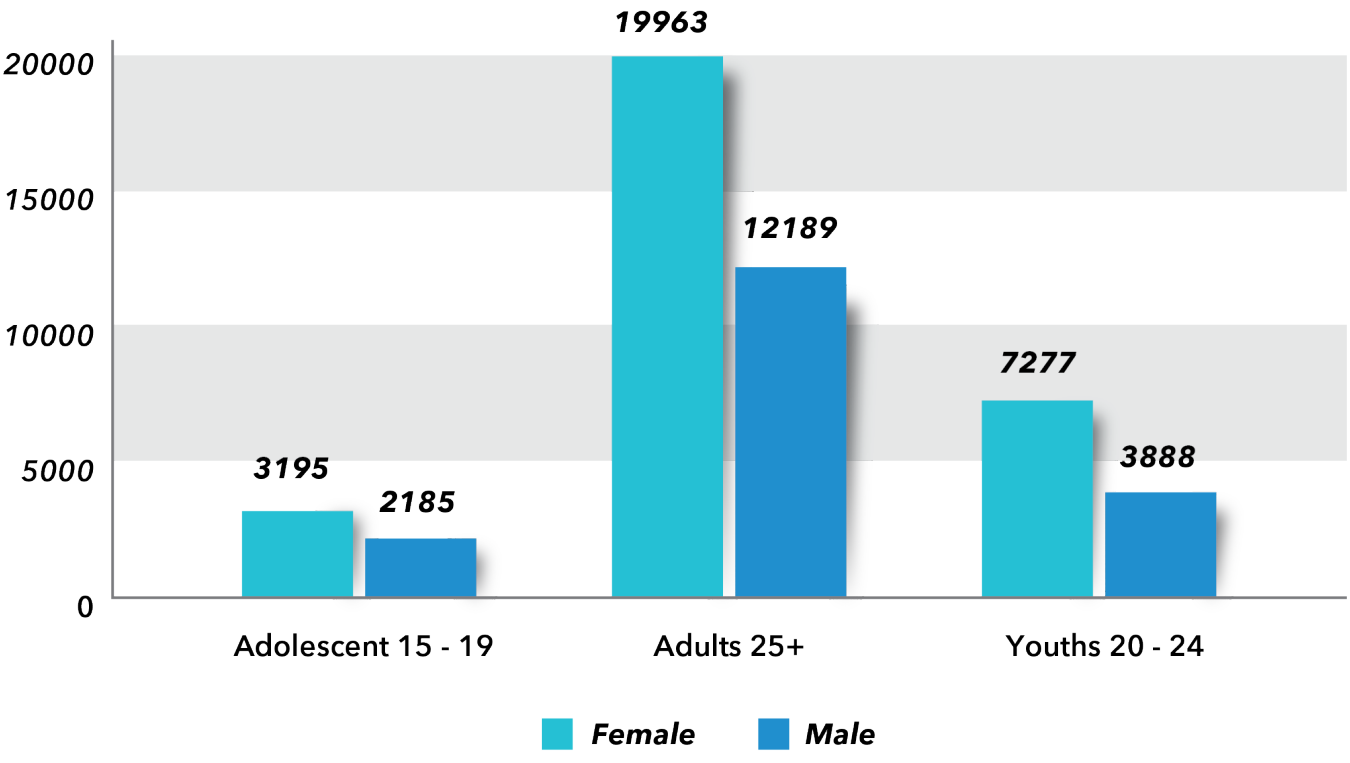
take place in low income, high prevalence and volatile communities, town centres, transportation hubs, places where people go to meet new sex partners (PLACE sites), sex work venues and socializing sites in and around high prevalence communities. In 2017, the services provided by outreach staff included: risk assessment and risk reduction conversations, condom negotiations and demonstrations, condom and lubricant distribution, HIV and Syphilis screening and referral for treatment.

HIV Testing

Increasing access to HIV testing continues to be a priority and is largely carried out by the Prevention Unit. During the year, four mobile testing units were operational in three Regional Health Authorities (South East Regional Health Authority (SRHA), North East Regional Health Authority (NERHA) and Western Regional Health Authority (WRHA)) and were scheduled to operate five days per week, targeting high prevalence communities, high transmission sites and key affected populations.

During the period under review, the Prevention Unit tested a total of 48,697 persons for HIV; 18,262 (38%) males and 30,435 (62%) females. Two thirds of the persons tested (32,152) were adults over 25 years old, followed by the young adults age 20-24 (11,165) and then adolescents in the 15-19 age range (5,380).

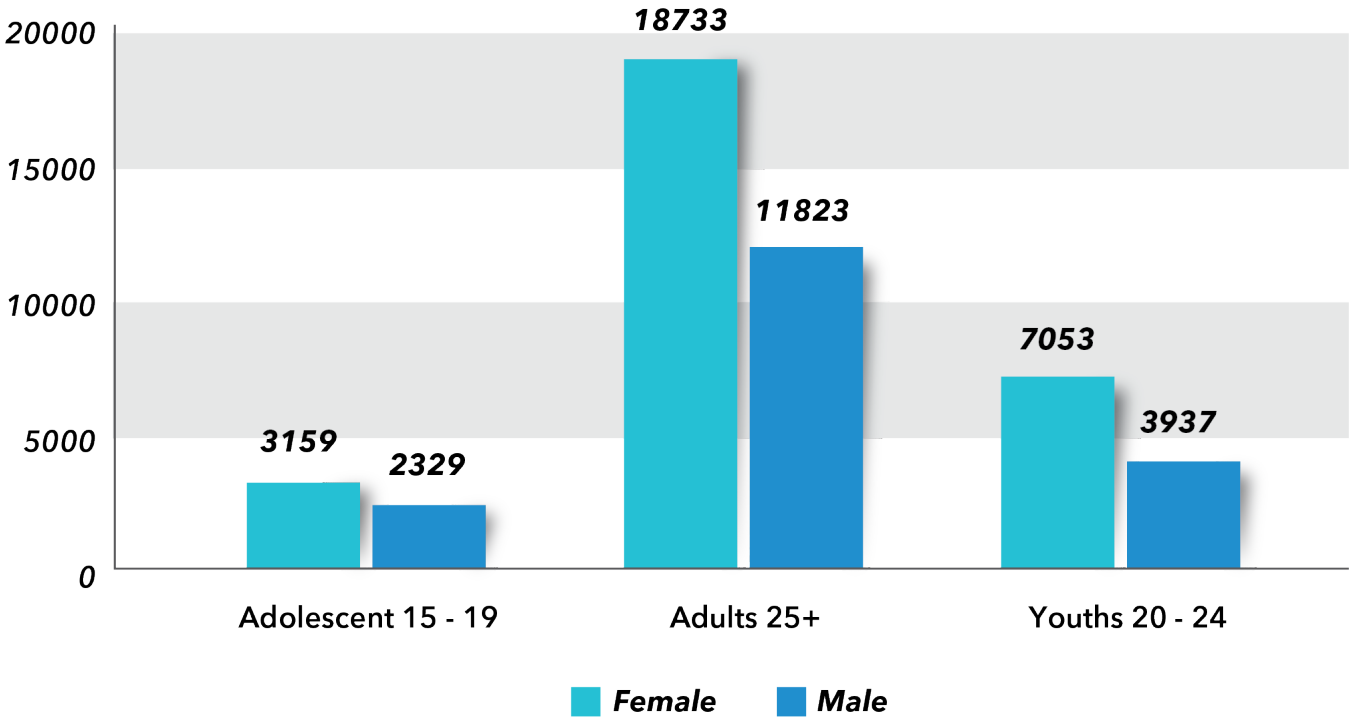
Fig. 6 Persons tested for HIV by Age and Gender



Syphilis Testing

During the year, the Programme continued to monitor Syphilis in outreach settings. Screening was done using the SD Bioline in accordance with the Ministry of Health's testing protocol. The Prevention team tested a total of 47,034 persons for Syphilis; 18,089 males and 28,945 females.

Fig. 7 Persons tested for Syphilis by Age and Gender



More females accessed the testing services than the males. This could be attributed to the fact that males have demonstrated poor health seeking behaviour. Additionally, males in the high-risk communities, often use the status of their female partners to assess their status.

HIV PREVENTION AMONG KEY POPULATIONS

In 2017, 10,693 MSM were reached through the efforts of the Prevention Unit; just over 50% were tested (5,759 persons). The challenges to reach the transgender population persists, however 654 were reached in 2017 and just over a half of that number (361) were tested.

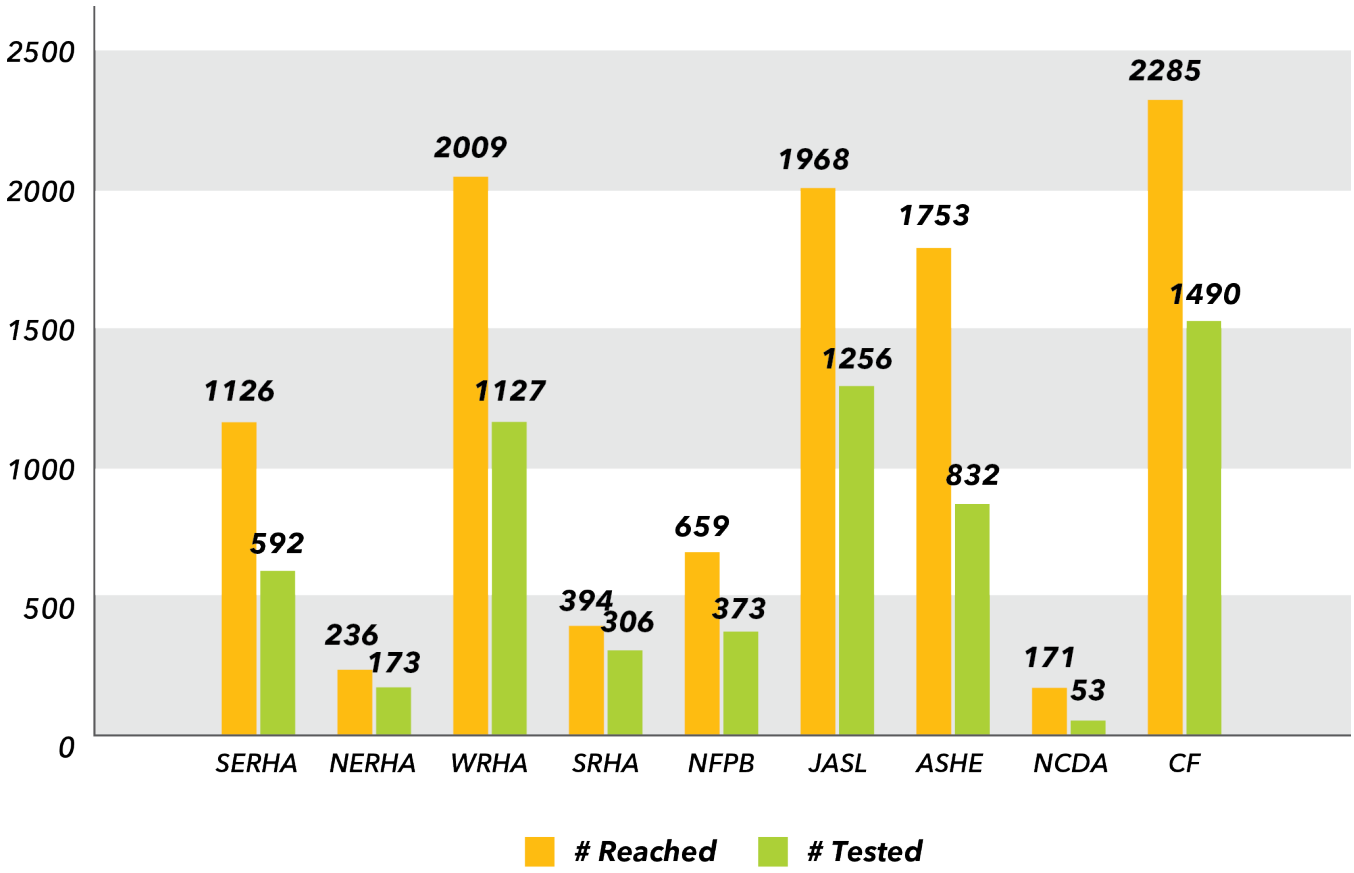
With respect to female sex workers, the cumulative number reached by the Unit in 2017 totalled 10,230 and 65% (6,694) were tested. These KPs were primarily reached and

tested through the outreach strategy which involved the distribution of condoms and lubricants and self efficacy skills building activities.

Men who have Sex with Men

Strategic and deliberate focus was given to this group by the Prevention Unit over the reporting period. As a result, 10,693 men were reached and 5,759 were tested. Children First reported reaching the most men, which accounted for a fraction over 20% of the total.

Fig. 8 MSM Reached and Tested



The strategies employed took the form of workshops, site based and venue-based interventions and use of peer links, one-to-one and snowballing. During the year, efforts were made to increase workplace interventions in hotels and call centres and to use home-based sites (also known as "lymes") and social media to increase reach and test of the population. MSM/TG were also reached at PLACE sites across the island, including popular restaurants, plazas/malls in the main town centres in the parishes, private homes

and churches. Site visits facilitated HIV prevention activities such as risk assessment and risk reduction conversations and discussions, condom skills building, as well as the distribution of condoms and lubricants to the population.

There was a significant reduction in the distribution of lubes to the MSM population in 2017 because of a national stock out of lubricants. Nonetheless the interactions with the population continued with an increased emphasis on condom building skills and condom distribution to heighten the awareness of the population of the need to protect against HIV.

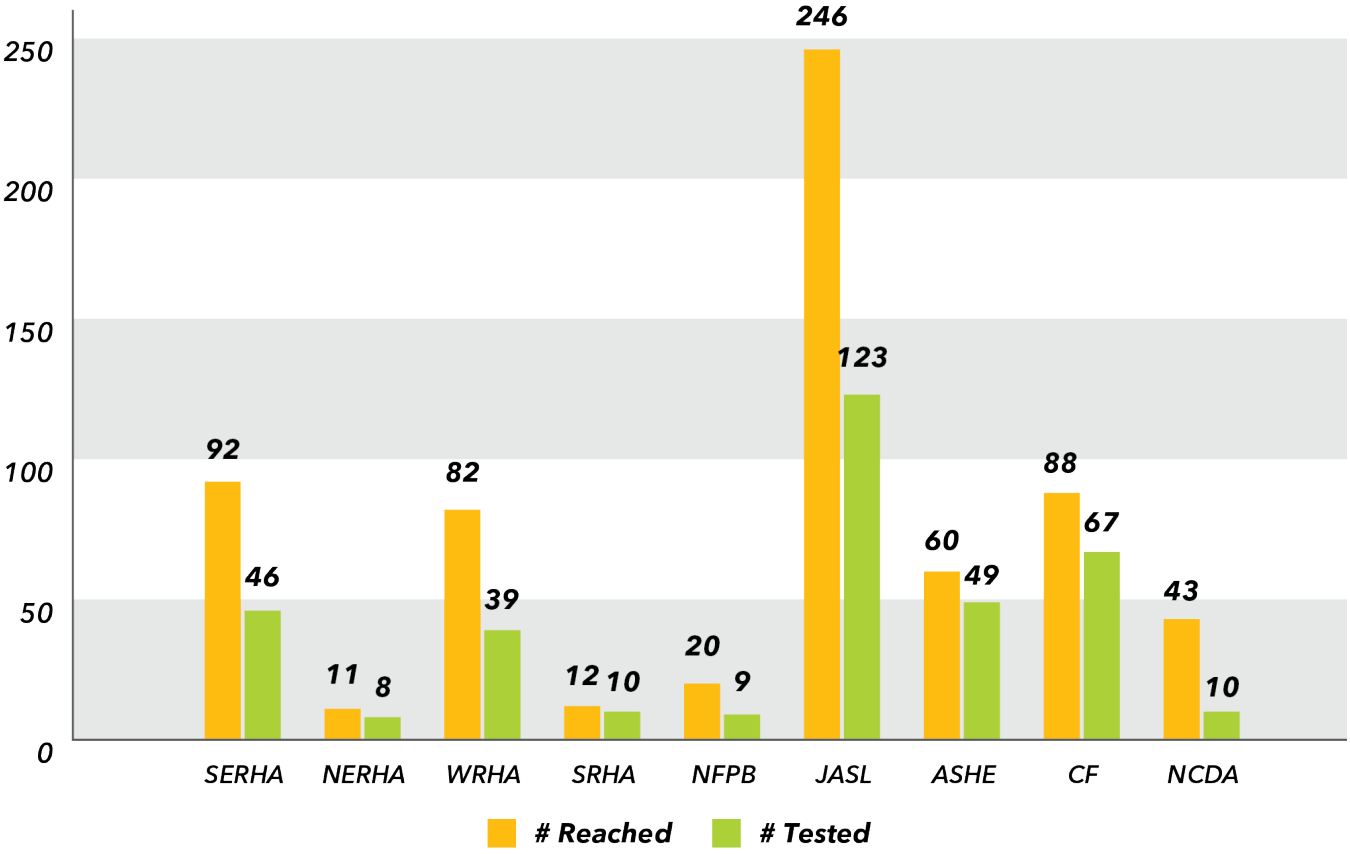
Persons of Trans-experience

This is still a relatively new area of focus. While the Prevention teams have improved testing among TGs, efforts to reach this group during the reporting period were hampered by the team's limited knowledge of the population. The team has indicated that in conversations with the TG population, some persons were having difficulty in identifying as "trans-gender"; they are still working through the dynamics of the change and are not yet ready to identify as trans-gender. Persons of trans-experience tend to be gender fluid and will change their gender often, sometimes identifying as males and sometimes as females. They also tend to change their sexual orientation. Therefore, the skills of the Prevention team members must be strengthened to work more effectively with this community.

In 2017, lyming continued to be the prime activity for engaging the TG community. The NFPB hosted one lyme for persons of trans-experience during the year; 15 participants were engaged in make-up artistry and provided with fashion tips and sexual and reproductive health information. The participants who attended the lyme had previously participated in MSM activities. Additionally, the Prevention Unit collaborated with two Kingston based party promoters and got the opportunity to engage with persons who would not have attended a site or venue-based intervention.

A total of 654 TGs were reached during 2017 and 361 were tested. Jamaica AIDS Support for Life reported reaching the most persons.

Fig. 9 TG Reached and Tested



Challenges

The Unit faced several challenges in 2017 with regards to the TG population, including:

1. Incentivized Participation. Lymes are mostly attended by MSM from the lower social and economic strata that have admittedly been to several other workshops. They have also 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.

2. Lack of safe spaces. This hampers the progress of the intervention as team members are hesitant to work at known MSM sites for fear of flare-up of violence or police raids. Both staff and participants are compromised by threats of violence.

3. Real and perceived stigma. Stigma within the community continues to hinder the progress of intervention. Persons fearful of receiving a positive result tend not to access testing services. In order to allay some of the fear the interactions with the population rely heavily on the 'Test and Start' strategy. Persons are provided with information on the possibility of becoming virally suppressed as an outcome of starting treatment if diagnosed as positive.

Trans Jamaicans Qualitative Research

A qualitative research was undertaken during the year to uncover information to assist HIV Programme planners in developing strategies and approaches to effectively identify, locate and engage people of trans-experience in comprehensive rights-based HIV programmes. Data was gathered from focus group discussions and interviews with thirty-one (31) persons of trans-experience.

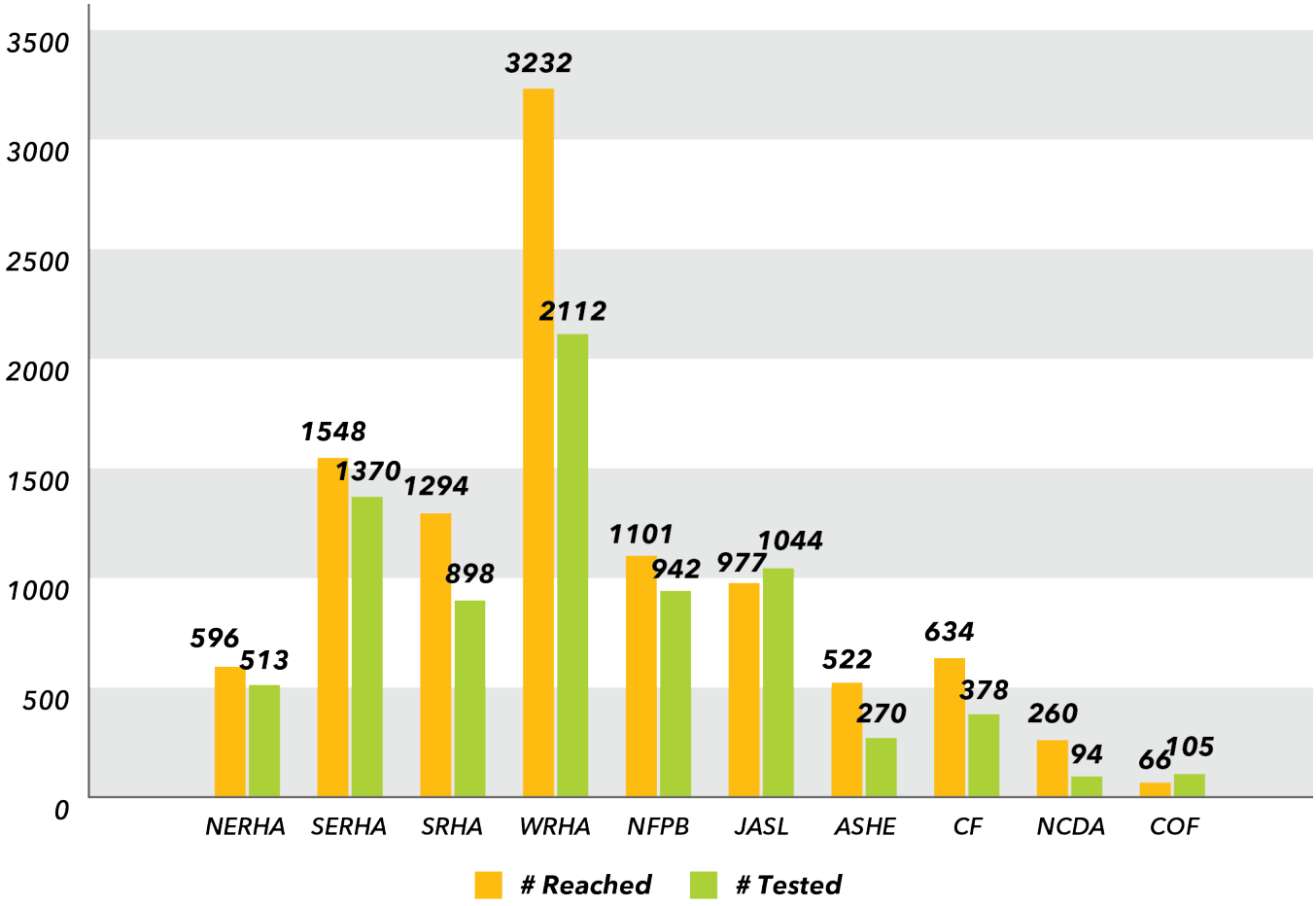
The following are some key recommendations from the study:

- The Ministry of Health and the Medical Association of Jamaica should take a policy approach and position on transgender health care to support capacity building and training of health providers and implement best practices and standards.
- Engage transgender people through a range of networks and offer HIV prevention, testing and treatment services that are delivered by trans-people to trans-people.
- Develop counselling service for people of trans-experience that could take the form of a co-counselling model by training trans-people in basic counselling skills to assist and support others.
- Stigma and discrimination and violence towards trans-people must be addressed. Key messages should be disseminated through public education campaigns on gender based violence and gender diversity.
- Identify trans friendly and trans competent health care providers in the public, private and civil society sectors to build a skill set of local expertise that can respond to the needs of trans Jamaicans.

Female Sex Workers

In 2017, the main strategy for engaging FSWs continued to be "reach and test" as a means of transition to the 'Test and Start' programme. A total of 10,230 females were reached and 6,694 were tested. Over 90,000 condoms were distributed. The women were engaged at clubs, street sites and massage parlours. The Prevention team maintained the emphasis on reaching female patrons who, as studies have shown, are also engaging in sex work.

Fig. 10 FSW Reached and Tested



The 2017 Bio-behavioural Study carried out among FSW and female workers and patrons has identified a new prevalence of 2% among the population. This is a decrease from 2.9% in 2014. The decrease may be attributed to the continuous presence of the Prevention team in the field.

During the year, a quantitative study was also conducted to gain insight into the challenges faced by HIV positive FSWs in accessing treatment care and support and to propose strategies to address the challenges identified. A few challenges were identified, including:

1. Perceptions and practices about eating food and medication.
2. Coping with the side effects of the medication.
3. Mobility of the sex workers to seek work locally and overseas.
4. Lack of privacy at the worksites.

5. Club operators demanding test results prior to employment.
6. FSW negative attitude towards HIV+ FSW.

The study outlined several recommendations to address some of the challenges:

1. Implement a strategy to improve treatment literacy among the population.
2. Strengthen the link between the Prevention and Care team.
3. Scale up and maintain site-based sensitization sessions with club operators .
4. Revise the system for providing HIV results at sex work sites.
5. Intensify strategies to work with families and communities to reduce stigma and discrimination and encourage support for family members.

These recommendations were accepted by the Prevention team and will form the basis of the work going forward.

Challenges

Overall, the challenges in reaching the FSWs include:

1. Duplication of efforts. FSW move from one parish or region to another, which leads to multiple agencies reaching and testing the same persons.
2. Identifying new sex work sites. The traditional sex work sites such as massage parlours and clubs have not been yielding new FSWs.
3. Migratory nature of FSW. The population is very mobile and this limits the opportunities for continuous interventions and monitoring.
4. Increase in the use of social media. It has become more difficult to engage FSWs in site-based interventions as more of them work from home and use their phones to contact their clients.

Correctional Institutions

Prevention interventions were conducted primarily in four (4) adult correctional institutions throughout the year: Tower Street Adult Correctional Centre (TSACC), St. Catherine Adult Correctional Centre (ST. CACC), Tamarind Farm Adult Correctional Centre (TFACC) and Fort Augusta Adult Correctional Centre (FAACC). Through collaboration with Health Thru Walls, additional testing was done in Horizon Adult Remand Centre (HARC), New Broughton Adult Correctional Centre (NBACC) and Richmond Farm Adult Correctional Centre (RFACC).

The objective of the SRH Programme in correctional institutions is two-fold: 1) to identify and provide treatment and care for STIs, 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 (ART) and adherence support, are offered to HIV positive inmates and upon release they are assigned to a Peer Navigator in their respective parishes.

Cumulatively, 1,858 inmates were tested for HIV and Syphilis in 2017. This resulted in the identification of 60 new cases of HIV and 21 new cases of Syphilis. Testing figures also included fourteen (14) self-identified MSMs and two (2) FSWs. All persons reactive for HIV and Syphilis were linked to care and the necessary follow up tests carried out. One-to-one and group educational sessions continued during the year with special emphasis on 'Test and Start'. The Unit also conducted educational sessions with visiting family members and friends at the visitor's area at TSACC and ST. CACC.

Table 1 Inmates Tested at Various Correctional Facilities

FACILITY	TESTED	HIV+	SYPHILIS
TSACC	522	15	9
FAAC	206	5	0
ST. CACC	667	26	9
TFACC	185	6	1
HARC	197	1	1
NBACC	37	1	1
RFACC	44	0	0
TOTAL	1,858	60	21

Challenges

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

1. Delay in results from National Public Health laboratory. Confirmatory results that should take two weeks can sometimes take up to six weeks or in some cases the results go missing.
2. Refusal to do blood work. Some inmates refuse to get their blood work done for varying reasons including, but not limited to, denial of their HIV status.
3. Medical information not being transferred with inmates. Inmates, including those who are HIV positive, are being transferred to other correctional institutions without their medical charts. This creates additional challenges for follow up care in the correctional system.
4. Staffing issues at TSACC result in difficulty assigning an escort to the Programme Officer. This was further complicated by the assault of a female human rights practitioner by

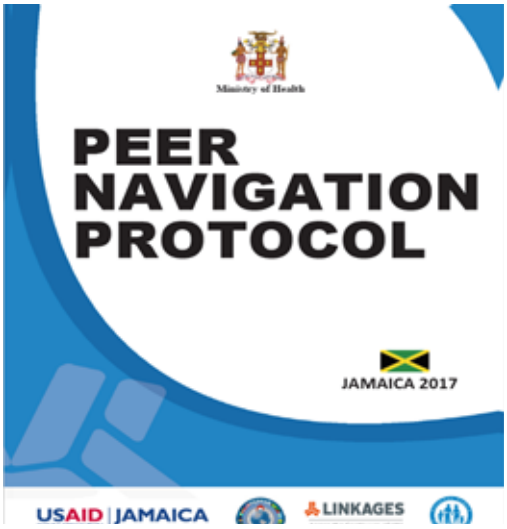
an inmate. Escorting protocols have since changed. An escort is to be accompanied by a member of the patrol team for both entry and exit of the respective areas within the institution.

5. Lack of condoms in institutions. The "no condoms in prison" policy makes it difficult for inmates to practice safe sex. Ongoing efforts will be made to advocate for the best interest of this population.

GENERAL POPULATION INTERVENTIONS

Peer Navigation

The Peer Navigation system was officially rolled out in January 2017. HIV navigation involves service delivery aimed at assisting clients to obtain timely, essential and appropriate HIV-related medical and social services to optimize their health and eventually achieve viral suppression. Navigation includes linking persons to health care systems, identifying and reducing barriers to care, and tailoring health education to the client to influence his or her health-related attitudes and behaviours. One hundred and twenty (120) persons from the RHAs, NFPB and seven (7) Civil Society Organizations (CSOs) were trained, certified and deployed in 2016. Coaching seminars are ongoing to keep the Navigators current with information to assist their clients. Their work in the field will be guided by a Peer Navigation Protocol that was also developed and disseminated.



Condom Demonstration and Distribution

In 2017, 304 condom outlets were established by NFPB and the RHAs. Through these outlets and outreach activities 5,599,330 condoms were distributed and the condom skills of 59,691 persons were enhanced.

Table 2 Summary of Condom Distribution & Demonstration by Region

CONDOMS	SERHA	NERHA	WRHA	SRHA	NFPB	NGO	TOTAL
Outlets established	40	74	146	30	14		304
Condoms distributed	1,788,800	820,476	1,714,100	974,500	109,454	192,000	5,599,330
Demonstrations	2,091	566	16,241	12,110	16,223	12,460	59,691

Themed Events

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

Safer Sex Week

Safer Sex Week was observed during the period February 13-17, 2017. In commemorating this special week, the national event was hosted at Prison Oval, Spanish Town, in St. Catherine on Tuesday, February 14 (Valentine's Day). A total of 1,675 persons were tested for both HIV and Syphilis during the Safer Sex Week of activities.

Counsellor at work at the NFPB/AHF Safer Sex Week at Spanish Town Prison Oval

Information Booth at the NFPB/AHF Safer Sex Week, Spanish Town Prison Oval

Regional Testing Day

The National Family Planning Board supported by Scotiabank, and with the partnership of the South East Regional Health Authority, commemorated Regional Testing Day on Friday, June 30. A total of 545 persons were tested for HIV/ Syphilis on that day.

Regional Testing Day 2017, Mandela Park

NFPB Information Booth at Regional Testing Day 2017

(L-R) The Hon. Minister of Health, Dr. Christopher Tufton, Dr. Denis Chevannes, Former Executive Director, NFPB, Ms. Manoela Manova, Country Director, UNAIDS and a representative from Scotiabank Jamaica at Regional Testing Day 2017

World AIDS Day

World AIDS Day 2017 themed 'Keep the Promise, Don't turn your back on me" was held in collaboration with AIDS Healthcare Foundation and JN+. The national activities for the period started with a media launch on November 16 at the Courtleigh Hotel. Guest Speaker, the Honourable Minister of Health, Mr. Christopher Tufton commended the efforts of the National Programme in its continuous work to achieve the UNAIDS 90-90-90 targets. The church service in honour of World AIDS Day was held at St. Luke's Anglican Church on November 26.

Hon. Minister of Health, Mr. Christopher Tufton at the Launch of World AIDS Day, 2017

World AIDS Day Church Service, St. Luke's Church, Kingston

The World AIDS Day 2017 celebration also featured a Song and Arts Competition targeting adolescents and young people between the age of 10 and 25 years. The competition was aimed at assessing their knowledge of AIDS/HIV issues while engaging their artistic skills to produce a poster or a song based on the theme. Entries were received from over 30 schools island-wide; 53 entries were received for the song competition and 72 for the visual arts competition. World AIDS Day activities culminated with a road march on December 1. Over 500 participants marched from Mandela Park to the Health Fair and Arts Competition finals at Emancipation Park.

The Song competition was won by the Greater Portmore Ensemble, Greater Portmore High School (10-15 age group category) and Tyrell Cammock from Excelsior High School (16-25 age group category). The winners for the Art competition were Odain Bryan from Bridgeport High School (10-15 age group category) and Haleem Lazaru from Pembroke Hall High School (16-25 age group category).

Students from Greater Portmore High School pose with their cheque after winning first place in the World AIDS Day song competition (10-14 age group). Director of Health Promotion and Prevention, Andrea Campbell, handed over the prize.

World AIDS Day 2017 Road March, Emancipation Park, St. Andrew

CAPACITY BUILDING OF OUTREACH WORKERS

During 2017, Outreach Workers were engaged in various in-service training activities to build their capacity to effectively execute their responsibilities. Training topics included:

- ***Motivational Interviewing -*** Outreach officers were introduced to practical techniques that can be used to assist their clients in resolving ambivalent feelings and insecurities that are preventing them from making healthier sexual choices.
- ***Gender Diversity -*** Outreach Officers were given tools to help develop a better understanding of gender and steps to gain support in the design of strategies to target individuals from diverse populations.
- ***Micro Planning -*** in collaboration with LINKAGES – Outreach officers were introduced to strategies that can be used to assess, prioritize and document the needs of individuals from the KPs in an effort to build rapport, encourage the building of networks and the development and maintenance of healthy sexual practices.
- ***Behaviour Change Communication Refresher -*** Strategies were introduced to assist in the creation of a supportive environment that enables individuals to initiate, sustain and maintain positive and desirable sexual reproductive health behaviours.

- ***Global Positioning System (GPS)/Geographic Information System (GIS) Mapping -*** Training was provided by the Ministry of Health on how to improve the work done with the key populations through geo-location.
- ***Peer Navigation Refresher –*** Peer navigation training sessions in linkage to care and treatment literacy were conducted across the island to equip Outreach Officers to guide their clients to become virally suppressed.
- ***Provider Initiated Testing and Counselling (PITC) -*** This training was conducted to increase the number of Outreach Officers offering HIV and Syphilis testing and counselling to clients who access care in public, private and NGO health facilities. Officers were provided with the opportunity to get accurate information on HIV/AIDS, HIV prevention, transmission and treatment and learn about the benefits and challenges of HIV Testing. Additionally, the training covered issues of confidentiality and consent and how to apply these in practice settings. Officers were trained how to administer HIV/Syphilis rapid screening tests and deliver results including referral to treatment, care and prevention support and partner notification.
- ***Social Media Platforms for Social Media Managers –*** Social Media Managers were trained on how to use various social media platforms to reduce the gap in reaching key populations. However, the implementation of this strategy on a wide-scale basis is still underway due to lack of the necessary devices and data plans.
- ***Treatment Literacy and Readiness –*** The training aimed to increase access to HIV care and treatment services by equipping Peer Navigators/Outreach Officers with the knowledge to dialogue with clients on matters related to treatment, care and support.
- ***Introduction to District Health Information System 2 (DHIS2) -*** DHIS2 is a tool used for collecting, validating, analyzing and presenting aggregated data. It allows for data to be captured in one central place. The system also assists in improving and increasing Programme impact by providing instantaneous reports. Outreach officers can gain feedback on work done, which helps to improve the facility's response and hence national response.

CHAPTER 3: TREATMENT, CARE AND SUPPORT

OVERVIEW

The Treatment, Care and Support Unit (TCS) is the technical arm of the HIV/STI/Tb Unit. The TCS team is charged with the responsibility of providing oversight in the treatment and holistic management of persons diagnosed with HIV/STIs and Tuberculosis (Tb). This involves several key activities and interagency collaborations that ultimately affect the patient outcomes and the outcome of the National HIV/STI/Tb Programme. The attainment of targets is necessary for not only patient outcomes, but also for national validation and continued donor support. Ongoing training, sensitization and evaluation are therefore essential.

The National Integrated Plan for Sexual and Reproductive Health has specific targets for the HSTU to achieve over the period 2014 - 2019. These include:

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

Based on 2017 data, approximately 78% of the estimated number of PLHIV have been diagnosed, 34% retained in care on ARVs and 17% virally suppressed. The aforementioned evidence is showing that much effort will be needed to scale up activities towards achieving significant improvement in the second and third "90's".

While there is significant focus on HIV, the plan also includes strategies geared at addressing the prevention and treatment of other STIs and Tb. Risky sexual behaviour increases the risk of acquiring a STI. Revamping the National STI Programme is therefore critical.

Tuberculosis is one of the major opportunistic infections affecting PLHIV. In 2015, Tuberculosis was one of the top ten causes of death globally and the leading cause of death worldwide from a single infectious agent. In 2015, it was responsible for more deaths than HIV and malaria and is the leading cause of death globally in persons affected by HIV.

In response to the need to strengthen the TCS response, additional staff were recruited including a Clinical Mentor to offer clinical assistance in managing PLHIV and Programme Development Officers charged with responsibility for the Tb, STI, elimination of mother-to-child transmission (EMTCT) and prevention of mother-to-child Transmission (PMTCT) programmes. All national TCS officers are assigned responsibilities related to programme management and implementation of work plan activities for the RHAs

TEST AND START MEDIA CAMPAIGN

"Get on yu meds and get on wid life" was the call to action for the HIV campaign launched in August 2017. The campaign focussed on adherence to anti-retroviral therapy, retention in care and reducing lost to follow up.

The campaign had three objectives: 1) complement and support the roll out of the 'Test and Start' programme which started in January 2017, 2) highlight the benefits of starting ART soon after diagnosis and 3) to encourage those who have started to stay on their medication and build awareness about HIV treatment by providing easily understood information about ART. It was targeted at: newly diagnosed persons; persons that are lost to follow up, who may not have been eligible for ART under the previous guidelines (CD4 of 500); PLHIV that practice a healthy lifestyle such as special diet, exercise and use alternative medicine to maintain good health and avoid ART and all PLHIV. The campaign which is still running features:

One 30 seconds television commercial: "Conscience"

This commercial shows an HIV positive young woman who is very conscious of her appearance. She is seen exercising as part of her healthy lifestyle routine. The only thing missing from this healthy routine is her ARVs. Even though she is living a "healthy"

lifestyle and seems to be in good health, her conscience warns her about the vagaries of the disease and finally convinces her to not take any chances and start taking her meds.

Three 20 seconds social media video treatments: New diagnosis, Side effects and Why Everyday

These videos are intended for social media placement but can also be placed on national television. They cover three major issues faced by persons living with HIV:

- What happens if I test positive for HIV?
- Why do I have to take the medication every day?
- How do I cope with side effects?

The video clips provide brief and simple information about each of these frequently asked questions.

One 30 seconds radio commercial

The radio commercial shares a conversation between two persons, one of whom has just tested positive for HIV. He is encouraged by a fellow PLHIV not to be daunted because there is medication available to support a long and healthy life. The importance of adherence is also reinforced with the message of taking ARVs every day!

Two posters

These posters reinforce the 'Test and Start' messages and were placed in both private and public health facilities as well as among civil society partners.

Poster 1: Very popular among younger PLHIV as it simply depicts how the ARVs "control" the HIV virus. The virus is shown locked in a cage with the key being held by the ARV (pill).

Poster 2: Support for people living with HIV is always critical in coping with the diagnosis and maintaining treatment regimen. This poster shows hands holding as a sign of care and support.

CONTINUUM OF CARE

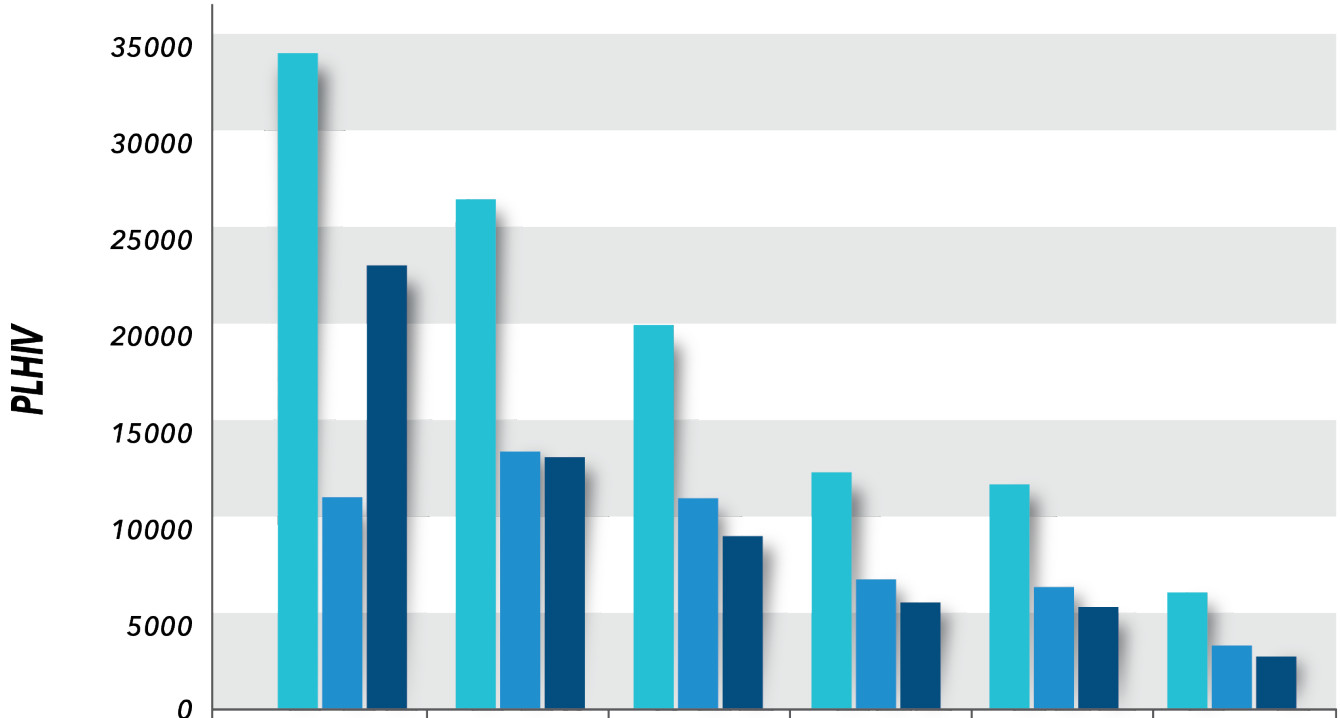
Linkage to Care

The HIV and AIDS epidemic, despite improvement in areas of the prevention of mother-to-child transmission and the reduction of HIV related deaths, still faces serious challenges. Gaps in the continuum of care continue to pose a problem especially in the areas of linkage and retention in care, and ARV coverage and viral suppression. This is compounded by barriers to care such as stigma and discrimination, staff shortages, inadequate linkages with civil society and private sector organizations among others. Despite this, efforts continue to be made to strengthen these links.

In 2017, the Ministry of Health adopted the 2015 WHO guidelines to "Treat All" based on findings noted in several studies which showed a reduction in morbidity and mortality if treatment was started at diagnosis.

The national treatment cascade illustrates the deficiencies in the continuum of HIV treatment and care that the country faces in meeting its treatment targets.

Fig. 11 National Treatment Cascade by Gender, December 2017



	Total PLHIV Estimated	PLHIV Diagnosed	PLHIV Ever linked to care	PLHIV Retained in care	PLHIV Retained in care on ARV	PLHIV Virally Suppressed
Total	34000	26426	19929	12291	11662	6068
Female	11000	13358	10948	6746	6352	3321
Male	23000	13068	8981	5545	5310	2747

Of the 34,000 individuals estimated to be living with HIV infection in Jamaica, approximately 78% have been diagnosed. There are various issues surrounding testing that limit the effectiveness of the response. Routine HIV testing is still not fully implemented throughout the health system. There continues to be low levels of Provider Initiated Testing in Accident and Emergency departments at some facilities, especially among patients admitted to hospitals. There has been a scale up of PITC training across the RHAs and reinforcement from the regional level, which has resulted in an improvement in uptake. This effort needs to be sustained.

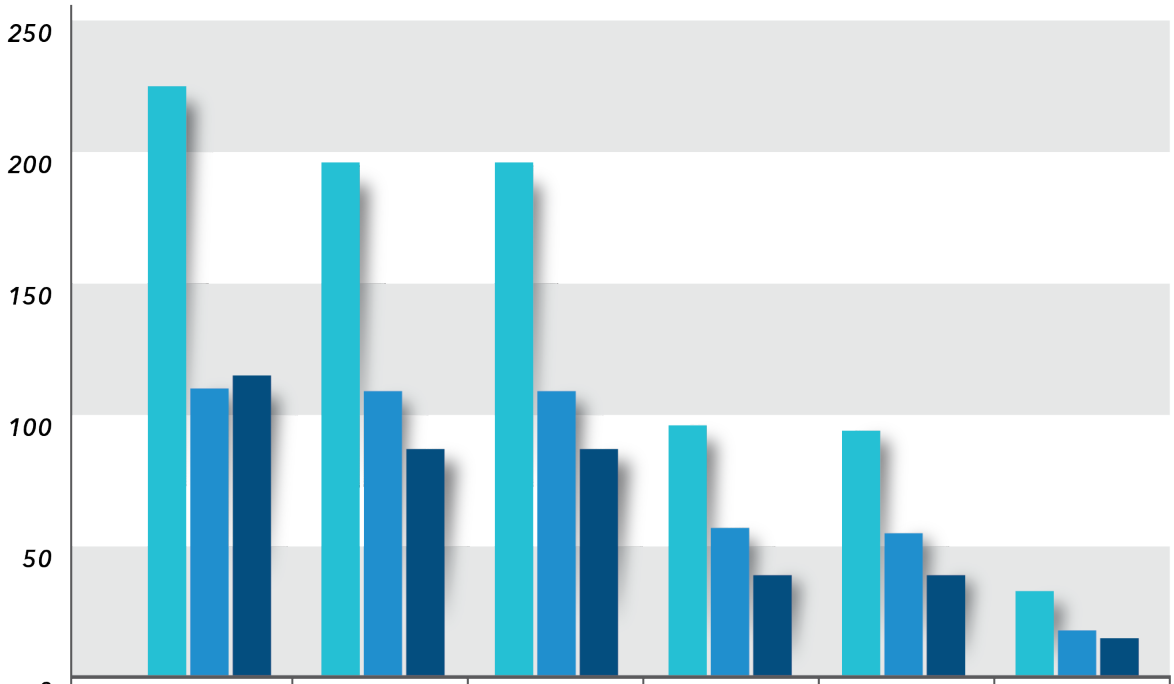
With regards to linkage, 75% of patients diagnosed have been linked to care, and of those linked, 62% have been retained in care. Of those retained in care, 95% are on ARVs but only 52% of those retained in care and on ARVs are virally suppressed. Through Quality Improvement (QI) activities, there is an emphasis on closing the gaps regarding lost to follow up and viral suppression at all sites and this process will continue into 2018. In order to formalize the institutionalization of QI activities, the Liaison and TCS Officers have been given the responsibility of overseeing implementation and ensuring that all sites have an active QI programme.

Youths and Adolescents

The data suggests that there is need for more focus on this population. Eighty-seven percent (87%) of the adolescent population were diagnosed HIV positive, all are linked to care (100%); 48% are retained in care on ARV, and 34% are virally suppressed. There are pending initiatives such as guidelines for adolescent support groups and adolescent specific assessment tools which are expected to improve the overall treatment, care and support offered to this population.

The Late Adolescent Cascade shows that 37% are linked to care; 16% are retained in care, 14% are retained in care on ARV, and only 4% are virally suppressed, indicating that there is need for more focus on this population. A lot of the patients transition from paediatric care to adult treatment sites during this age range. The transitional period can be difficult and if not carefully monitored the patients can be negatively affected. This population is also likely to benefit from the guidelines for adolescent support groups and adolescent specific assessment tools.

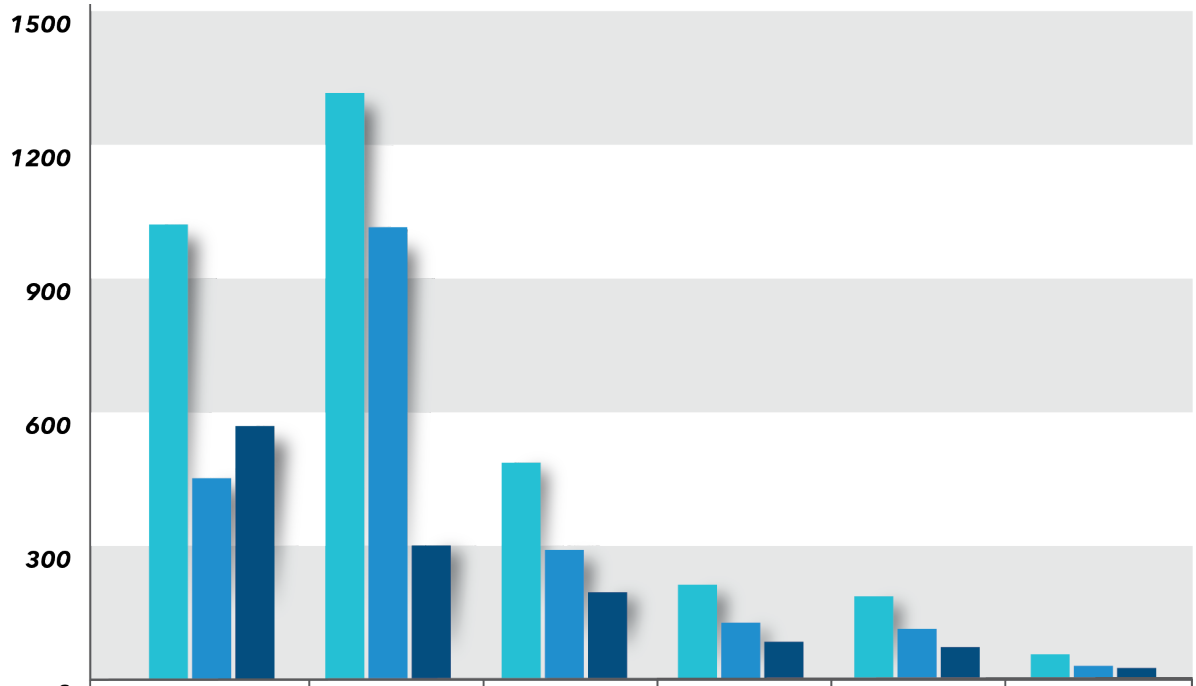
Fig. 12 Adolescent (Ages 10-14) Treatment Cascade for 2017



	Adolescent PLHIV (Aged 10-14) Estimated	Adolescent PLHIV (Aged 10-14) Diagnosed	Adolescent PLHIV (Aged 10-14) Linked to Care	Adolescent PLHIV (Aged 10-14) Retained in Care	Adolescent PLHIV (Aged 10-14) Retained in Care on ARV	Adolescent PLHIV (Aged 10-14) Virally Supressed
Total	225	196	196	96	94	33
Male	110	109	109	57	55	18
Female	115	87	87	39	39	15

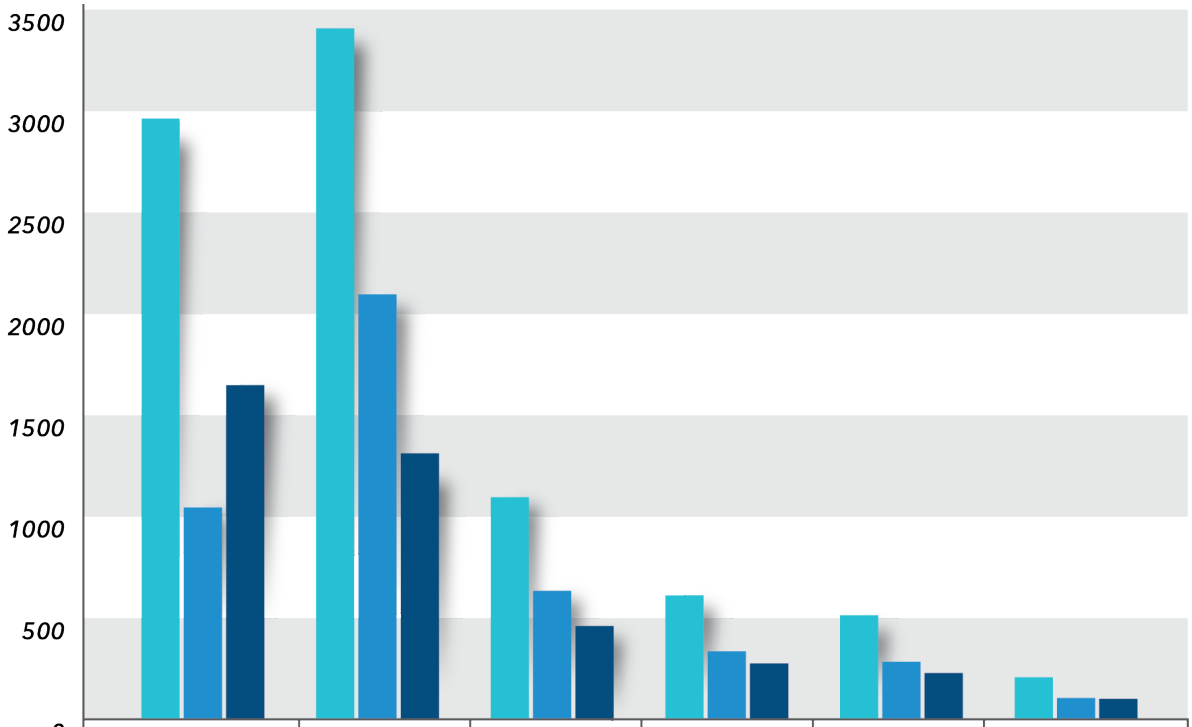
The Cascade for youths, ages 20-24, shows that 32% are linked to care, 18% are retained in care, 15% are retained in care on ARV, and only 6% are virally suppressed. Overall, the cascades highlight the need for more work to be done with the key population groups and the different age groups. The virally suppressed percentage is low in all the cascades. This could indicate that while persons are being tested and linked to care, there continues to be adherence issues.

Fig. 13 Adolescent (Ages 15-19) Treatment Cascade for 2017



	Adolescent PLHIV (Aged 15 -19) Estimated	Adolescent PLHIV (Aged 15 -19) Diagnosed	Adolescent PLHIV (Aged 15 -19) Linked to Care	Adolescent PLHIV (Aged 15 -19) Retained in Care	Adolescent PLHIV (Aged 15 -19) Retained in Care on ARV	Adolescent PLHIV (Aged 15 -19) Virally Supressed
Total	225	1021	487	213	187	57
Male	110	1015	291	128	114	31
Female	115	301	196	85	73	26

Fig. 14 Youth (Ages 20-24) Treatment Cascade for 2017



	PLHIV (Aged 20 - 24) Estimated	PLHIV (Aged 20 - 24) Diagnosed	PLHIV (Aged 20 - 24) Linked to Care	PLHIV (Aged 20 - 24) Retained in Care	PLHIV (Aged 20 - 24) Retained in Care on ARV	PLHIV (Aged 20 - 24) Virally Supressed
Total	2694	3408	1096	612	514	208
Male	1045	2096	635	336	285	106
Female	1649	1312	461	276	229	102

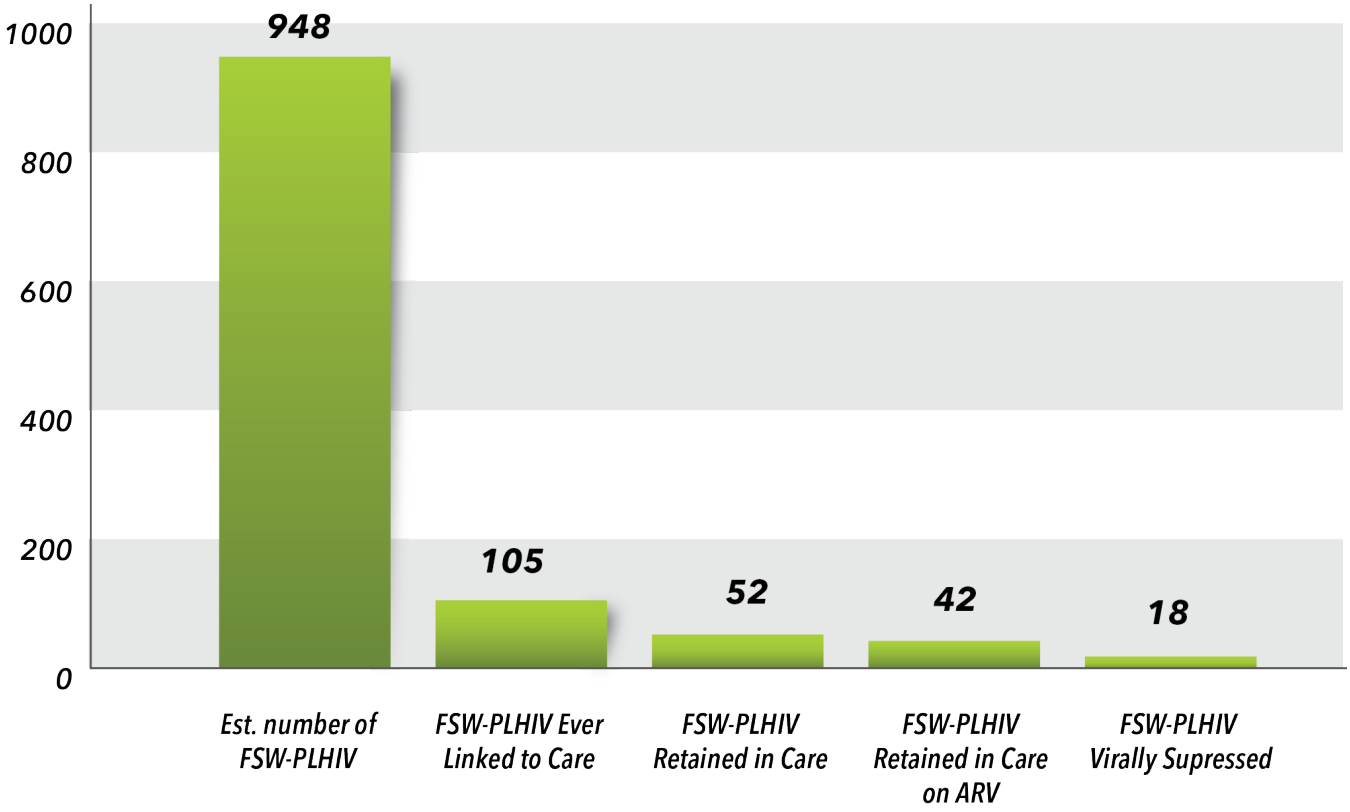
The treatment cascades for some of the key populations are presented in the remainder of this section. Lack of disclosure of KP status in treatment settings is a major influence on the cascades of FSWs and MSM.

Female Sex Workers

There have been great successes with the female sex worker community. The infection rates among sex workers have shown reductions, falling from a high of 12% in 1990 to 9% in 2004, and from 4.1% in 2011/2012 to 2% in 2017. The diagnosis of this key population is still a challenge. There is less success with linkage to care, adhering to medication and achieving viral suppression. The FSW cascade reflects that only 17% of FSWs are virally suppressed. In an attempt to address the gaps in the cascade, a study was conducted to: identify the gaps/challenges in HIV positive FSWs accessing treatment, care and support;

determine the factors influencing the adherence to medication and viral suppression among FSWs and identify measures which can be implemented to address the challenges highlighted by the study. Based on the study, the factors hindering adherence include the mobility of FSWs, treatment illiteracy, non-disclosure and stigma and discrimination among other factors. After the dissemination of the findings of the research, each region designed plans to address the gaps and improve the number of virally suppressed FSWs.

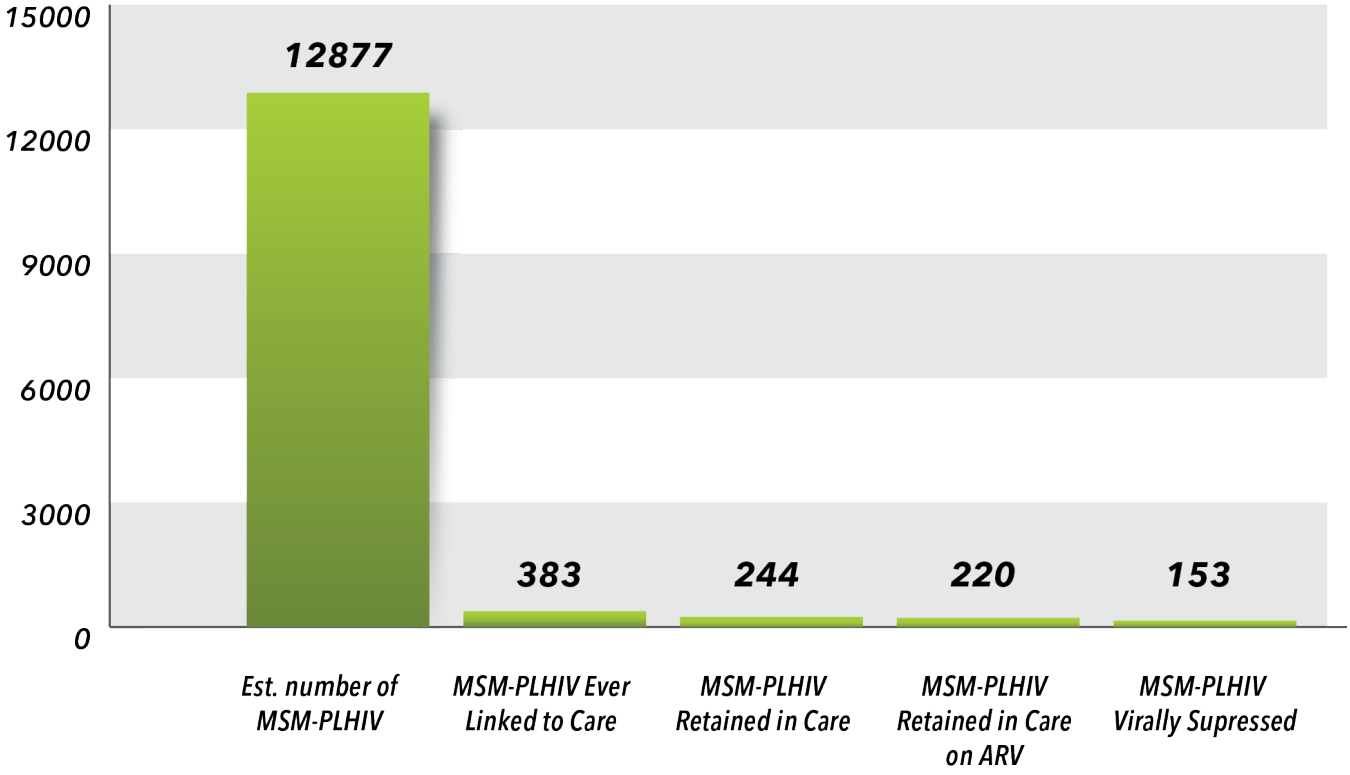
Fig. 15 National Female Sex Workers Treatment Cascade 2017



Men who have Sex with Men

The MSM and the FSW cascade have a common thread with linkage to care, the FSWs with more success that MSM. MSM are doing better in terms of viral suppression. The workshops and sensitizations sessions being conducted with the MSM community may have contributed to the 40% viral suppression.

Fig. 16 National Men who have sex with men (MSM) Treatment Cascade 2017



HIV TESTING

Testing data received from 8 of 14 private laboratories across the island are shown in Table 3. For 2017, these laboratories report having conducted 39,190 HIV tests with 184 (0.5%) being positive. This is a decline over the number of tests conducted in 2016, 47,330 with a yield of 0.8% (368), as reported by private laboratories.

Table 3 HIV Testing in the Jamaican Private Laboratories, January to December 2017

MONTH	TOTAL HIV TESTS DONE	HIV POSITIVE TEST RESULTS	% POSITIVE
January	3,526	16	0.5
February	3,692	12	0.3
March	1,183	3	0.3
April	86	1	1.2
May	184	2	1.1
June	4,203	17	0.4
July	5,916	28	0.5
August	4,347	25	0.6
September	5,194	29	0.7
October	3,535	18	0.5
November	3,447	16	0.5
December	3,877	17	0.4
Total	39,190	180	0.5

Eight (8) of 14 labs reported throughout 2017, however of these only 5 submitted more than 50% of the expected monthly reports. For the months of March and April only 2 laboratories reported and only 3 for the month of May.

In 2017, at least 136,454 HIV tests were conducted in the public sector across all regions (Table 4). This reflects a slight increase of 168 in the number of conducted tests reported when compared to 2016. Some challenges experienced in 2017 contributed to decreased numbers of testing and testing results received in the months of September and October. These include absent data due to reports not being received for some key parishes and a shortage of HIV Determine Test Kits in September 2017 due to shipment delays arising from adverse weather events in the region. The number of positive tests in 2017 resulted in a yield of 1.9%, which was a slight decrease compared to 2.0% in 2016.

Table 4 HIV Testing in the Jamaican Private Laboratories, January to December 2017

MONTH	TOTAL HIV TESTS DONE	HIV POSITIVE TEST RESULTS	% POSITIVE
January	12,298	276	2.2
February	13,029	231	1.8
March	11,319	190	1.7
April	12,217	293	2.4
May	11,297	259	2.3
June	13,280	201	1.5
July	13,538	300	2.2
August	11,475	209	1.8
September	6,229*	240	3.9
October	6,612**	79	1.2
November	13,826	202	1.5
December	11,334	180	1.6
Total	136,454	2,660	1.9

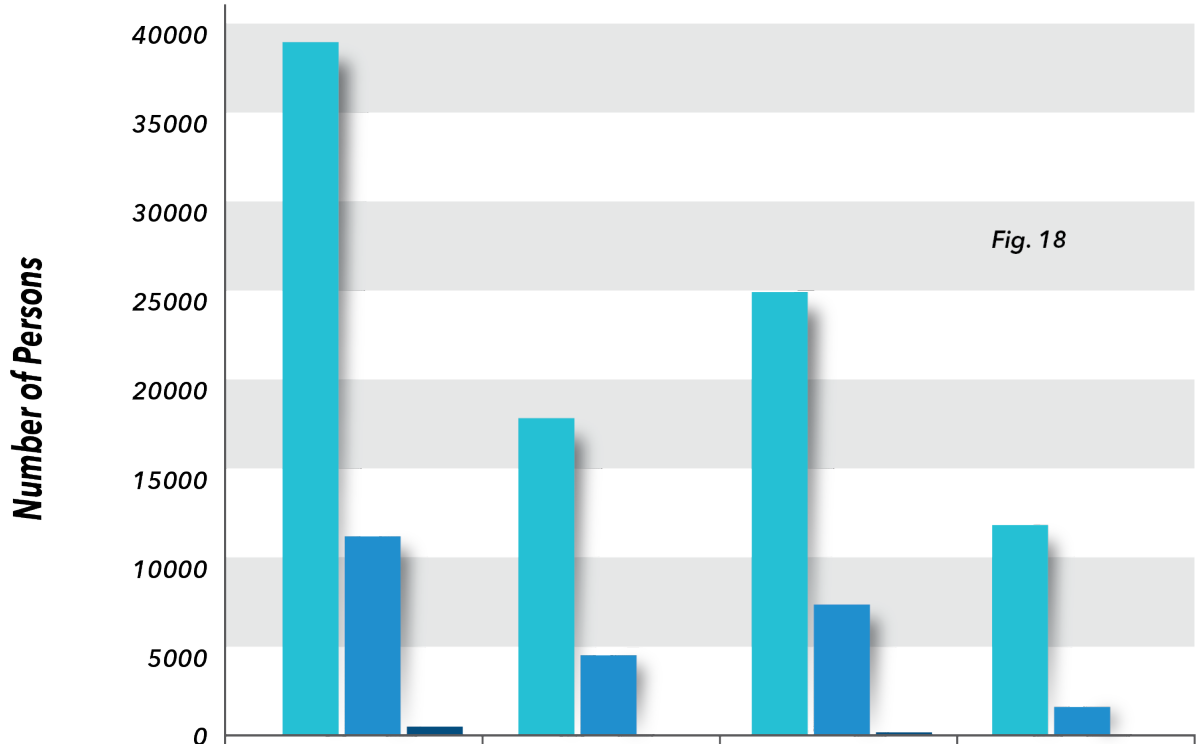
** No HIV regional/ parish lab report received from St. Catherine for this month*
*** No HIV parish lab report received from St. Catherine, Kingston and St. Andrew*

Provider Initiated Testing and Counselling

The RHAs continued to build the capacity of health care workers in public health facilities and CSOs to conduct PITC. Persons trained in 2016 conducted training sessions throughout 2017 for new staff within their respective regions.

Improvements were seen in PITC for two RHAs for 2017. Each region developed an action plan to improve testing rates; among the activities that they have embarked upon is re-sensitization of critical members to the importance and process of early diagnosis. Additionally, PITC graphs were distributed across sites to allow for the tracking of testing figures on a weekly basis. This gave each site the opportunity to track their performance and discuss ways for improvement. Scientific approaches learnt through the Quality Improvement (QI) Collaborative can also be used to measure the impact of interventions.

Fig. 17 PITC Uptake in Jamaican Hospitals January to December 2017



	SERHA	NERHA	SRHA	WRHA
Total Hospital Admissions (Excluding Obstetric)	38,956	17,824	24,909	11,828
Admissions tested for HIV	11,184	4,505	7,359	1,607
Admissions tested positive for HIV	496	49	178	43
PITC Yield %	4.4%	1.1%	2.4%	2.7%

In 2017, there was an average PITC uptake of 28.7% in SERHA and 25.3% in NERHA. Compared to 2016, this represents a marginal increase of 0.7% and 0.3%, respectively. SRHA's uptake was 29.5%, a decline of 3.5% compared to the previous year. WRHA also showed a decline of 2.4%. The environmental issues persist at Cornwall Regional Hospital (CRH) and may be contributory factors to the decrease in PITC figures reported for this region.

Treatment with ARVs

The 'Test and Start' initiative was rolled out in January 2017. A constant supply of ARVs is essential to support this initiative. The challenges experienced with ARV stock levels

in 2016 demanded changes in the forecasting and planning mechanisms to prevent national stock outs of ARVs. Through the assistance of USAID, training was carried out with members of the TCS and SI Unit on the Quantimed and Pipeline software. This software assists with the forecasting of ARV needs and allows planned ordering of ARVs based on data inputted relating to the number of patients on the various treatment regimens, usage pattern and expected attrition, movement between treatment lines and number of new cases detected.

An ARV tracking tool was developed by the TCS Unit which records quantities of ARVs and test kits in stock at the National Health Fund warehouse. This tool details the average monthly usage of the ARVs, expected deliveries of ARVs, expiry dates, expected duration of ARVs in stock and the expected duration of ARVs with upcoming deliveries. This tool has allowed the easy visualization and early identification of ARV levels allowing timely ordering and delivery lead times. Increased collaboration with the NHF warehouse team has also been initiated. This involves quarterly meetings with NHF warehouse staff, sharing of monthly inventory, receival and dispatch reports, and biannual auditing of stock levels of pharmaceuticals and non-pharmaceuticals.

Two ARV orders were procured through the Global Fund pooled procurement mechanism (WAMBO) process in 2017. Delays in receiving some of these shipments resulted in a stock out of ARVs at some treatment sites. Recirculation of ARVs between ARV dispensing pharmacies minimized the interruption of patient treatment and prevented patients from being switched to alternate regimens.

Pharmacy reports were not received from all ARV dispensing pharmacies throughout the period. Notably, the National Health Fund assumed the management of all government pharmacies in 2017. This change will lead to a standardized management structure, which is expected to result in improved compliance with reporting schedules.

A quality assurance plan is being prepared with the assistance of the USAID. This plan will aid in ensuring the quality of ARV drugs obtained through the WAMBO process. It is expected that the completed plan will be implemented in 2018.

Laboratory Monitoring Tests

The number of PCR tests conducted in 2017 decreased compared to the previous year with a notable decrease in the rejected samples. CD4 testing also decreased with a decrease in the number of rejected samples. The number of viral load tests conducted increased during the year. This was expected with the initiation of 'Test and Start' in January 2017.

Table 5 Monitoring Tests for 2015-2017

	PCR			CD4			VIRAL LOAD		
YEAR	2015	2016	2017	2015	2016	2017	2015	2016	2017
Received	978	1,124	982	14,627	14,227	10,295	15,097	17,743	19,232
Processed	912	1,070	953	14,053	13,749	9,956	14,775	17,331	18,917
Positive	11	15	12						
Rejected	66	56	29	574	478	339	322	412	315
Rejection Rate %	6.7	4.9	2.0	3.9	3.4	3.2	2.1	2.3	1.6

Early Diagnosis of HIV Exposed Infants - DNA PCR Testing

DNA PCR testing is used as a means of early detection for HIV in perinatally exposed infants. The testing algorithm dictates that HIV exposed infants are given a PCR test at 6 weeks and then 3 months. Additionally, at 18 months, an ELISA test (HIV antibody test) should be done to complete the algorithm. In 2017, 982 DNA PCR tests were conducted with 12 positive results. Of those tested positive, 6 represented first PCR tests for babies born in 2017, 2 represented second PCR tests for babies born in 2017 and the remaining 4 were second and third PCR tests for babies born in 2016.

There was a decrease in the number of rejected DNA PCR samples in 2017 compared to previous years. This may be attributed to the interventions by the Immunology and Quality Assurance Units of the National Public Health Lab in re-sensitizing officers to use the correct technique for sample collection and packaging. There was no stock out of reagents in 2017.

CD4 Testing

The CD4 test acts to monitor the HIV disease stage of PLHIV as it indicates the level of immune system impairment. As per national guidelines, all diagnosed persons should receive an initial test to determine their CD4 count upon linkage to the care team and twice annually until stable, then discontinue. However, treatment should start regardless of one's CD4 count based on the WHO 2015 "Treat All" guidelines that were implemented in January 2017.

In 2017, 10,295 CD4 tests were received. This was a 27% reduction in the number of requests received in 2017 compared to the previous year, which was anticipated based on the shift in the guideline. There was also a reduction in the number of rejected samples in 2017 compared to previous years. The issuing of job aides and re-sensitization sessions on sample collection and storage, conducted by the NPHL and the HSTU, contributed to this reduction.

The FACS Calibur machine at Cornwall Regional Hospital was in a state of disrepair for most of 2017 but the FACS Count from SRHA was utilized in the interim. A FACS Presto machine was assigned to WRHA.

Approximately 30% of CD4 testing was done on point of care machines, with a rejection rate of less than 1%. In 2017, all PIMA machines were serviced by the manufacturer and a retraining session was conducted. All sites have subsequently been certified except Black River which is currently undergoing certification. With regards the FACS Presto platform, only one site remains to be certified; certification is currently underway. There were no stock out of FACS Presto and PIMA reagents in 2017.

Viral Load Testing

Viral load testing is used as an indicator to see how well the immune system is fighting the HIV virus. National guidelines dictate that viral load assessment should be done six months after starting ART and then twice annually until the patient is virally suppressed. Thereafter the test should be conducted annually.

In 2017, viral load testing increased by 11% compared to the previous year. Improvements were also seen in the number of rejected samples for 2017 when compared to both 2016 and 2015. Notably, 282 requests for viral load tests were submitted to the Immunology Unit of the NPHL in 2017 without accompanying samples. This issue is currently being addressed by the NPHL.

There was an increase in the turnaround time for viral load results, which was brought to the attention of the NPHL. NPHL subsequently implemented the following guidelines, which resulted in a reduction in delays towards the latter part of 2017:

1. A direct telephone line was established at Sample Reception so that sites are able to call directly to check on the status of their results.
2. A line listing template was developed so that the sites can document pertinent information about the samples that are being sent as well as use the tool to follow up on the results.

The NPHL has tested these two interventions using Plan Do Study Act (PDSA) cycles and have found them to yield some level of success in improving efficiency.

At the national level, the HSTU, in collaboration with University of California, San Francisco, is in the process of merging the Treatment Site Information System and DISA Lab. Sites that have completed the merger are able to access viral load results in real time, provided that the information in TSIS is identical to the information in DISA Lab. It is anticipated that the merger will be completed for all sites in 2018.

Site Mentoring Team

During 2017, the Site Mentoring team was conceptualized as a new initiative to focus on the steps needed to achieve the UNAIDS 90-90-90 target. It is comprised of a Clinical

Mentor (Team Lead), Pharmacist, Strategic Information officers and Treatment & Liaison Officers from the NFPB. As a first step, the team performs audits on the HIV treatment sites by assessing:

1. Clinical, laboratory and pharmaceutical services
2. PITC and PMTCT programmes
3. Linkage to care, adherence and missed appointment process
4. The presence of the QI initiative

In an attempt to improve the retention in care, there is also an assessment of: patient's aspects of privacy and confidentiality; whether the site is KP friendly or not and how sexual and reproductive health has been incorporated into HIV care. The first region assessed was SRHA. The audit findings were analyzed and site-specific plans were formulated to address the gaps identified. The recommendations from the preliminary analysis of the audit are outlined below:

1. Documentation of clinical notes needs to be improved.
2. More detailed notes should be prepared by the Psychosocial team and included in the docket.
3. Completed Treatment Readiness Assessment and Social Intake Assessment Tools should be included in the docket.
4. Social Work Sessional Forms should be used to document visits with the Social Worker and included in the docket.
5. Evidence of objective adherence assessments e.g. pill counts should be performed and documented in the docket.
6. Input from the nutritional service needs to be more regularized and improved.
7. Regular review of dockets of PLHIVs on ART, who have elevated viral loads, need to be done so that cases of poor adherence and viral resistance can be identified.
8. The name and position of team members should be clearly written on notes that are placed in the docket.

SUPPORT

Psychosocial Support

The TCS Component of the HSTU provides support for PLHIVs through the Psychosocial Support team which includes Adherence Counsellors (ACs), Social Workers (SWs), Psychologists and Case Managers (CMs). This cadre of staff assists PLHIVs through counselling, psychosocial support and mental health assessments. The team also assists with addressing social and emotional barriers in accessing HIV treatment, care and support

services.

In 2017, a lot of emphasis was placed on building the capacity of team members and standardizing practice and documentation systems across the four RHAs. With the assistance of the International Training and Education Center for Health, Washington, Seattle, the Unit completed the development of the CMs' curriculum and successfully implemented a training of trainers (TOT) activity. The Unit now has access to 23 trained CM Trainers, drawn from several departments in the MOH, who will be implementing the CM curriculum early in 2018. Also completed was the ACs' protocol, which will guide the standardization of adherence counselling practice across RHAs. The ACs' curriculum was also initiated, and Psychologists were given access to PsycArticles on the American Psychological Association online platform.

In 2016 the Unit established itself as the initiator and driver of the treatment readiness campaign, in preparation for the January 2017 adoption of the WHO guidelines for the management of HIV, "Treat All". This necessitated ongoing capacity building of all levels of staff in 2017; priority was given to staff that were not exposed in the 2016 round of training. These included Community Health Aides, Community Facilitators and the Prevention team. The year also saw the full implementation of the treatment readiness assessment tool (TRAT), which is now the standard means of determining the readiness of PLHIV for ART. The Home Visit Form was also introduced, and along with the TRAT, is steadily gaining in popularity.

In 2017, the Unit took several tangible steps geared at improving retention in care and on ARVs, as well as viral suppression. Among them was the introduction of food vouchers for PLHIVs in collaboration with AIDS Healthcare Foundation (AHF). Although the national spread of this facility was and still is, somewhat limited, the initial reviews are promising; PLHIVs are expressing more interest in attending clinic.

Another major intervention during the year was the emphasis placed on developing and operating real support groups. After discovering that several different types of groups were being mislabelled "support groups", the Unit set out to correct the error and build capacity of staff around support groups. Genuine support groups are now established across all the RHAs; only a few treatment sites do not have at least one active group.

Among the greatest challenges for the team is the chronic absence of adequate spaces for members of the Psychosocial Support team to meet and work with clients. It is not unusual to see three officers, each having a client, sharing a small meeting room.

Quality Improvement Programme

Supported by the International Training and Education Center for Health (I-TECH), a center in the University of Washington's Department of Global Health, TCS Unit continued to work on Quality Improvement at the HIV Treatment sites. As per the PEPFAR/HIV Testing Services Jamaica work plan, ITECH worked with 12 of the 21 previous participating sites that are considered as high priority sites. Quality Improvement activities at the non-PEPFAR

sites resumed in April 2017 after a brief halt, with monitoring by the TCS Officers at the regional and national levels.

The sites focused on adherence and retention to care to increase viral suppression at the treatment sites. The treatment site teams tested different PDSA cycles throughout the year. With the increased emphasis on differentiated care, sites were encouraged to test change concepts on stable versus unstable patients. Mandeville Health Centre tested whether stable patients will pick up medication and complete laboratory work on time, when given a six months appointment. Some sites also focused on improving the documentation of adherence through the administration of Self reporting questionnaires (SRQ). Other sites tested if telephone calls would result in patients keeping their appointment.

All the QI teams at treatment sites included a community representative (patient). This patient would attend and actively participate in QI team meetings and bring fresh perspective and insights from the patients' point of view. Sites were encouraged to focus on incorporating and replicating those PDSAs that yielded positive test results.

Towards the latter part of 2017, there was a shift in focus to the sustainability of the QI initiative. In order to strengthen this new thrust, a sustainability committee was established with all the key stakeholders. Meetings were held, and will continue, with the regional authorities, Medical Officers of Health and MOH representatives to create awareness and garner support at the leadership level.

The final learning session for the year was held in December. It focused on more aggressive management of the unsuppressed ART patient in order to improve the viral suppression rate of the treatment sites; a viral load algorithm was presented and reviewed as a first step. The early detection of viral resistance will continue to be an important focus of the QI initiative in 2018.

ELIMINATION OF MOTHER-TO-CHILD TRANSMISSION OF HIV & SYPHILIS

The Elimination of Mother-To-Child Transmission of HIV & Syphilis by 2015 in the Americas continues to be the aim of the Prevention of Mother-To-Child Transmission of HIV & Syphilis Programme in Jamaica. This WHO target has been subsumed into Jamaica's National Integrated Strategic Plan (NISP) for Sexual and Reproductive Health, ensuring the efforts of the HSTU are in tandem with those of the Family Health Unit (FHU) and the NFBP, the two main providers of SRH care in the island.

At the National level, capacity building within the programme improved in 2017 with the assignment of a Programme Development Officer from within the HSTU to PMTCT. The Development Officer works in collaboration with focal points within the SI Unit. Confirmation of positive cases of HIV & Syphilis infants continued through a robust notification process at the National Surveillance Unit (NSU). The NSU serves a dual purpose as it also enables the validation of field reports received directly by the HSTU. The EMTCT Oversight Committee inclusive of paediatricians, gynaecologists, past Jamaica Paediatric, Perinatal

and Adolescent HIV/AIDS Programme (JaPPAIDS) committee members, donors and NGO representatives continued to give technical expertise and guidance to this aspect of the nation's response to the epidemic.

At the sub-national level, the PMTCT programme begins with PITC testing during the antenatal period at both public and private health care facilities. Documentation of positivity rates in both HIV and Syphilis, appropriate treatment inclusive of drugs and dosing, outcome and final status of delivered infants were recorded in the monthly PMTCT reports submitted to the HSTU via an electronic reporting account, which was introduced in 2017. Challenges specific to Syphilis, such as comparatively lower testing rates than HIV and poor documentation of the clinical follow-up and treatment of the mother/infant pair, were countered with the introduction of Maternal Syphilis and Syphilis Exposed Infant Registers in the latter quarter of 2017. PMTCT Coordinators, Nurses, Clinicians and relevant support staff such as Regional Coordinators, Contact Investigators (CIs), Social Workers and Adherence Counsellors have been trained in the use of these new and updated quality data collection tools. The relevant private sector health care workers (HCWs) were also included to enable an all-encompassing national response. In keeping with the latest WHO standards, the PMTCT program has set out to achieve:

- 2% or less rate of MTCT for HIV
- 0.3 per 1000 live births annual rate of new infections of HIV and
- 0.5 per 1000 live births annual rate of Congenital Syphilis

Table 6 EMTCT validation indicators for Jamaica 2015 – 2017

Impact indicators	Target	2015			2016			2017		
		Result	Num	Den	Result	Num	Den	Result	Num	Den
HIV MTCT rate	<2%	1%	5	345	1%	5	429	6%	16	270
Annual rate of new inf. Per 1000 infections	<0.3	0.13	5	37,556	0.139	5	35,959	0.47	10	33,979
Annual rate of CS per 1000 live births	<0.5	0.08	3	37,556	0.22	8	35,959	0.24	8	33,979

Number of confirmed cases of Congenital Syphilis by case surveillance definition obtained from the HSTU/NSU

The target for HIV MTCT rate was not met for the year (Table 6). Discussions are ongoing within the HSTU on the best approach to managing this emergent issue. A detailed case-based investigation is in progress.

The Way Forward

In 2018, all efforts will be geared to Jamaica's achievement of Elimination Status. Maintenance of this status involves the following:

1. Proper PITC testing at all labour ward and delivery suites in the 3rd trimester and for un-booked mothers. This gap was made evident by the 2017 PMTCT programme analysis and the results of an ongoing Site Mentoring Team evaluation.
2. Improved user-friendly data collection mechanisms with a by-product of enhanced monitoring and evaluation of the programme through:
    a. A web-based PMTCT monthly reporting form capable of producing comprehensive annual reports that may be site specific, region specific or give the national picture, inclusive of specific EMTCT indicator filtering that aids in donor reporting mechanisms.
    b. Offered consultancies with organizations such as the University of California San Francisco (UCSF) on improved data visualization to improve delays in implementing corrective measures for each site and motivating sub-national staff in the achievement and maintenance of elimination targets.
3. Capacity Building through: the employment of an EMTCT National Validation Field Coordinator to monitor and bridge programme gaps between the national and sub-national level; printing of the updated PMTCT Manual and Easy Reference Guides and continued training of staff, at both national and sub-national levels of programme management, on updated PMTCT protocols and guidelines. These will be made possible with funding assistance from UNAIDS United Budget, Results and Accountability Framework (UBRAF), UNICEF and the Pan American Health Organization (PAHO), respectively.
4. Sustainability of the programme with the absorption of the cadre of PMTCT Nurses by the regions and the GOJ budget providing programme specific funding for 2018/2019.
5. Adaptation of EMTCT plus, to include the MTCT of Hepatitis B, as prioritized by the WHO. This will warrant close collaboration with the FHU.

SEXUALLY TRANSMITTED INFECTIONS

Jamaica's response to sexually transmitted infections has been overshadowed by the ongoing response to HIV. Nevertheless, all other STIs such as Syphilis, Gonorrhea, Chlamydia and Trichomonas remain a global and national issue. The risky behaviour profile and demographic and cultural factors that predispose persons to contracting STIs remain rampant in our population. These were reported in the 2012 KABP survey and included: early initiation of sexual activity, at an average of 15 years; a culture of multiple sex partners; gender inequality and gender roles; homophobia; stigma and discrimination

and economic hardships. Knowledge of STIs is declining in both sexes, which is reflected in the worsening trend of risky behaviour choices.

Antimicrobial resistance of several pathogens responsible for STIs was seen globally in 2017, especially for gonorrhoea, threatening the effectiveness of current curative regimes. A sentinel survey is underway. Samples are being tested in Sweden for the possibility of drug resistance in the treatment of Gonorrhoea, Syphilis, Trichomoniasis and Mycoplasma. Data for some major STIs, obtained from the NSU, are shown in Table 7 and indicates a downward trend for most despite the Jamaican cultural and socio-economic context.

Table 7 STIs Reported, 2016 – 2017

Sexually Transmitted Infections	Male		Female	
	2016	2017	2016	2017
Syphilis	482	471	590	566
Chlamydia	567	425	694	575
Genital Discharge Syndrome	7,532	7,581	29,995	28,384
Genital Ulcer Disease	15	0	23	4
Trichomoniasis	15	0	409	544
Genital Warts	440	387	487	463

The NISP for 2014-2019 ensures that the MOH's mandate for the integration of SRH and HIV/STI services into Jamaica's priority health targets are met. Whilst efforts geared towards the comprehensive management of SRH involves prevention and contraception mechanisms such as condom use and dual family planning methods from the NFBP and the FHU respectively, the HSTU is tasked with program management of treatment, care and support for STIs.

Syndromic management of STIs continued to be the cornerstone of the strategy to decrease its spread and the associated adverse effects in Jamaica. STI treatment is accessible, affordable and appropriate on the first encounter with a physician in the public health system at a primary health care facility. At this point, identifying and treating a common set of signs and symptoms (syndromes) is the most feasible option for Jamaica. Whilst capacity building of clinicians for curative services and CIs for partner notification and testing continues to be adequate, surveillance of STIs as Class 3 Notifiable Diseases and laboratory identification of pathogens is less than ideal. Despite the decreasing trends noted prior, more steps are necessary in strengthening of the national and sub-national STI programme. A recently conducted SITAN made possible through funding from PAHO gave several recommendations and reiterated the importance of those given in the Pan Caribbean Partnership against HIV/AIDS STI Surveillance Report (2012). One of

the recommendations was the establishment of an STI Technical Working Group (TWG), which will be formed in the first quarter of 2018, with key stakeholders from the NPHL, ITECH, medical stalwarts in the field of STIs and representatives from PAHO and UCSF.

The Way Forward

Over the next year, and beyond, the TCS Unit is aiming to:

1. Formulate an overarching roadmap for STIs in Jamaica, that considers the current state of affairs, implements recommendations from the 2017 SITAN and determines the most feasible approach for the continued holistic management of STIs. This is especially needed in the context of syndromic versus case based management. The HSTU will be looking to determine what patterns, from the State of California, which transitioned from syndromic to case-based management of STIs, can be applied in the Jamaican context.
2. Capacity building through the retraining of clinicians, FNPs, curative nurses and current CIs in STI management. The continuation of CI training will be made possible by USAID and aims to increase the manpower needed for proper partner notification and testing for HIV and other STIs.
3. Improved visibility of the national STI response via:
    a. Updating of the MOH's website with available STI information such as the 2017 SITAN.
    b. Linking the NSU database, which is used to report aggregate STI data, to a main server within the HSTU for associated dashboards at a sub-national level.
4. Improved quality data collection of STIs by:
    a. Revamping the use of the STI Clinical Summary Sheet for all patients being treated for a STI at all primary health care facilities.
    b. Engaging the Health Records department to obtain STI data from the MCSR so that it may be triangulated with data received by the NSU from CIs in the field.
    c. Conducting a STI prevalence study at the main STI clinics initially to get a true representation of the burden of STIs in our population. This will be sustained by a possible pairing of the annual STI prevalence survey with the annual HIV sero-prevalence survey.
    d. Determining the response of the private sector in the management of STIs through both private physicians and private laboratories.
5. Improve surveillance of STIs by establishing sentinel site surveillance of the most prevalent STIs at one main referral STI clinic in each region. This will enable the Comprehensive Health Center to become the main and final referral point for STIs in Jamaica.

6. Establish Jamaica as a WHO STI sentinel site in Latin America so that STI prevalence data for the region may be obtained.

TUBERCULOSIS

Tuberculosis is the leading cause of death worldwide from a single infectious agent and is also the leading cause of death in persons affected with HIV. Accordingly, it has received an intensified global response and action including the World Health Organization's END Tb strategy. This END Tb strategy provides a unified response to ending Tb deaths, disease and suffering, and builds on three pillars:

1. Integrated patient-centered Tb care and prevention
2. Bold policies and supportive systems.
3. Intensified research and innovation.

In Jamaica, the Tuberculosis prevention and control programme was integrated with the National HIV/STI Programme in 2016 to form the HIV/STI/Tb Unit. This integration was an effort to improve the efficiency and effectiveness of the Tb programme. Despite this integration, challenges persisted due to a lack of adequate staff both in the HSTU and the NSU, which delayed activities associated with the Tb arm of the Programme. To alleviate this the HSTU employed additional staff in 2017, including a Programme Development Officer whose tasks include management of the Tuberculosis component.

Table 8 Tuberculosis cases in Jamaica 2012-2017

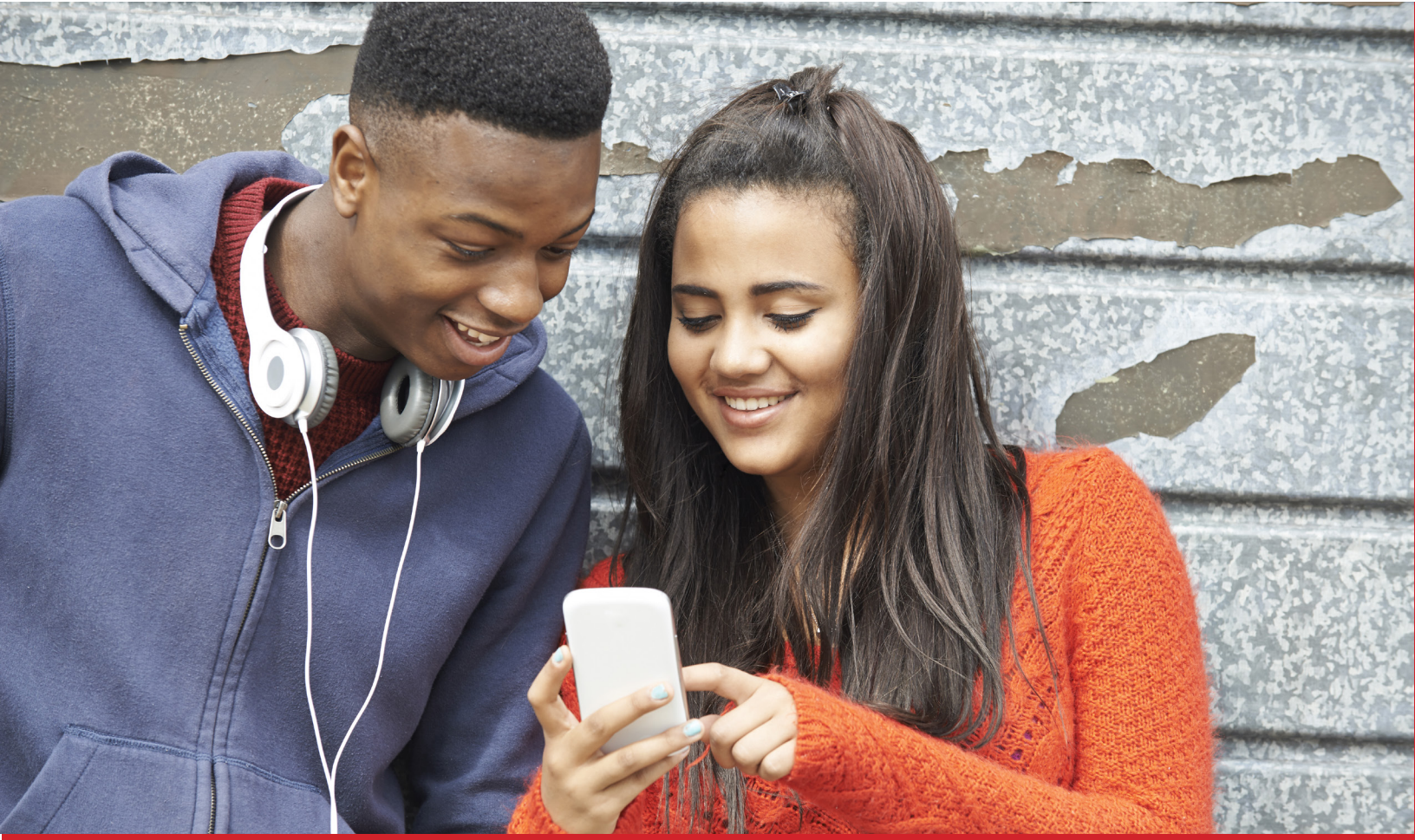
CASES	2012	2013	2014	2015	2016	2017
Number of Tb cases detected	94	96	86	103	103	124
Number screened for HIV	65	95	79	66	56	99
% of Tb cases screened for HIV	69.1	98.9	91.9	64.1	54.4	79.8
Of cases screened, # co-infected	15	16	19	15	28	20
% of cases co-infected	23	16.8	24.1	22.7	50	16.12

Data Source: WHO Global Tb Report Jamaica

Several major programme challenges were identified in 2017, including some in the areas of case detection and laboratory testing. Initiatives to address these include:

1. Revision of the National Tuberculosis Treatment Manual. This will consist of a series of technical working group meetings involving members with expertise in laboratory and clinical management of Tuberculosis as well as epidemiological and surveillance expertise. These meetings are scheduled to begin in January 2018.
2. Development of the National Strategic Plan for Tuberculosis 2019-2023. A Consultant was recruited, with the assistance of PAHO, and the draft strategic plan was completed in December 2017. The Tb TWG will be tasked with reviewing and finalizing this document.
3. Strengthening the National Public Health Laboratory's capacity in Tuberculosis testing. Smear microscopy was restarted in December 2016. The HSTU with the assistance of the Health Promotion and Prevention Unit, will be procuring GeneXpert cartridges, which are expected to arrive in January 2018.
4. Development of National treatment and laboratory algorithms. This is in keeping with global standards for Tb diagnosis and treatment, which will build the capacity of HCWs.
5. Improvements in reporting mechanisms and monitoring and evaluation. This will strengthen surveillance and improve the quality of Tb data collected.

These initiatives coupled with increased collaboration between the HSTU and NSU are expected to enable a decrease in the incidence of Tb in Jamaica and improve the delivery of service to affected persons and their families.



CHAPTER 4: ADOLESCENT HEALTH

OVERVIEW

The Adolescent Health component of the National HIV/STI Programme is a relatively 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 mandate of the Adolescent Health 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 2017.

TEEN HUB- HALF WAY TREE TRANSPORT CENTRE

The Teen Hub located at the Half Way Tree Transport Centre opened its doors to adolescents and youths in May 2017. Interventions at the Teen Hub are implemented through the collaborative efforts of the HIV/STI/Tb Unit and the Family Health Unit. The services offered are HIV and Syphilis testing, mental health screening, career guidance and wrap sessions. During the year, a total of 2,665 young people visited the Hub and 657 HIV tests were conducted by the National Family Planning Board and Civil Society Partners.

The Teen Hub was introduced as a response to reports of negative behaviours such as violence, truancy and risky sexual behaviours of adolescents at the Half Way Tree Transport Centre. Importantly, the Teen Hub provides a safe space for young people to access services such as HIV and Syphilis testing and prevention-risk reduction interventions.

Hon. Minister of Health Dr. Christopher Tufton (centre) and State Minister in the Ministry of Education, Youth and Information, Floyd Green (right), cut the ribbon to open the 'Teen Hub' in the Half Way Tree Transport Centre, St. Andrew

A baseline survey was conducted among teens 16-24 years before the Hub commenced operations. The mean age of participants was 17 years. They were asked a wide range of questions regarding their physical, mental and emotional health. The survey results showed an urgent need for intervention, as seen below:

- 73% of participants reported being in a relationship
- 58% reported being sexually active
- 35% reported not using a condom the last time they had sex
- 76% said they had never done an HIV test

These behaviours increase the risk of HIV infection and other STIs. Going forward, programme implementation will involve ongoing evaluation of the strategies designed to mitigate against these risks.

YOUTH AND ADOLESCENT TECHNICAL WORKING GROUP

The Youth and Adolescent Technical Working Group met quarterly throughout 2017 to discuss "hot button" issues and to plan advocacy strategies for getting their voices heard in order to make a difference. The main topics that young people wanted to address were the revision of the sexual offences act and comprehensive sexuality education in schools. YATWG members also benefitted from training in sexual and reproductive health rights, human rights, understanding social and legal barriers and advocacy.

Members of the Youth and Adolescent Technical Working Group

ADOLESCENT STANDARDS AND CRITERIA

Ten (10) quality standards and related criteria were approved by the Ministry of Health and a process to pilot test them was implemented in June 2015. Following the pilot test in seven sites, the MOH introduced a limited rollout of the standards (Cycle 1) in two health centres and will implement a full rollout in each health region (Cycle 2) in 2018. The table below provides information on each of the facilities selected to participate in the Cycle 2 rollout in the four health regions. At the end of this rollout cycle, a total of 18 health facilities would have been introduced to the quality standards for adolescent health, bringing the total number of adolescent friendly health facilities to 18.

Table 9 Health Facilities Selected in Cycle 2 of the Rollout of Adolescent Health Standards

HEALTH REGION	HEALTH FACILITIES		
	Number Selected	Name	Type
North East (NERHA)	2	Annotto Bay HC	III
		Port Antonio HC	IV
South East (SERHA)	3	Comprehensive HC	V
		Edna Manley HC	III
		Morant Bay HC	IV
Southern (SRHA)	2	Christiana HC	III
		May Pen HC	III
Western (WRHA)	2	Albert Town HC	III
		Darliston HC	III

During the year, the fifth round of training linked to implementation of the adolescent health standards was hosted for the 9 new rollout sites (Cycle 2) that serve adolescent clients. The training, which was completed between March 27 and May 5, 2017, was a collaboration between the Adolescent Health Unit and the HIV (All-In) Programme of the Ministry of Health. Financial support for the series of workshops was provided by PEPFAR/USAID, PAHO through its Jamaica Office and the United Nations Children's Fund (UNICEF) Kingston Office.

CHAPTER 5: ENABLING ENVIRONMENT & HUMAN RIGHTS

OVERVIEW

The work of the National Family Planning Board's Enabling Environment and Human Rights Unit is a critical component of Jamaica's programming for HIV/AIDS, STIs and sexual and reproductive health. The promotion and protection of human rights inclusive of sexual and reproductive health rights are integral to the creation of a supportive, discrimination free environment for all Jamaicans to access SRH information, goods and services.

During 2017, the Unit engaged service level staff, programme implementers and policymakers to ensure that all Jamaicans have equitable access to HIV and sexual and reproductive health treatment, care, prevention services and support. This was done through advocacy and the promotion of multi-sectoral policies and programmes. The Unit made notable achievements during the year:

- Facilitated collaboration and partnerships among internal and external stakeholders to revise the National HIV Policy.
- Successfully advocated for stronger accountability mechanisms to support complaints of HIV-related discrimination in employment settings at the Ministry of Labour and Social Security (MLSS).

- Developed a protocol and directory of service providers for inclusion in a national referral mechanism that links social protection agencies and civil society with national health systems in order to mitigate social and economic risks for key and vulnerable persons in the national response for HIV and SRH.
- Strengthened community systems to promote greater involvement of communities in the promotion and protection of human rights through policy monitoring and accountability tools and mechanisms.
- Promoted training strategies and interventions that reduce stigma and discrimination (S&D) associated with SRH issues, including family planning, HIV and other STIs for key and vulnerable populations.
- Established a multidisciplinary legal and policy review committee to coordinate the development of policy positions, use of findings from previous legal reviews, compilation of best practices and production of other communications to inform and guide SRH Advocacy Strategy.

Devon Gabourel, Director of the Enabling Environment and Human Rights Unit, speaking at a Safer Sex Week event

ADDRESSING GAPS IN POLICY AND LEGISLATIVE FRAMEWORK

During 2017, the EEHR Unit pursued actions to strengthen policy and legal framework for SRH and HIV prevention, treatment and care services. These initiatives were to address policy and legislative barriers to SRH information, goods and services.

A legal and policy review committee was established to coordinate the development of policy positions, use of findings from previous legal reviews, compilation of best practices and production of other communications to inform and guide SRH Advocacy Strategy. The Unit convened six (6) legal and policy review committee meetings and two (2) dissemination meetings to coordinate the development, printing and dissemination of policy positions and legal briefs. The Committee was established in March 2017 and comprised representatives from key Government Ministries, Departments and Agencies, civil society organisations, and international development partners. Two policy briefs were drafted and endorsed by the Committee on the topics of HIV Sensitive Social Protection and Recommendations to address discrimination based on health status with particular focus on HIV and SRH needs.

The Legal and Policy Review Committee in session

During the year, the Unit pursued actions to update and finalise the National HIV/AIDS Policy to reflect the outcomes of public consultations held in 2016 as well as policy developments in the sexual and reproductive health response. An updated version of the Policy, along with the requisite validation tools, was produced and agreement secured

with the Social Development Commission (SDC) to coordinate five (5) regional public meetings during the third quarter of 2018 to validate the finalised policy document. The National Family Planning Board will present the validated document and the respective submissions to Cabinet for approval in 2018.

The EEHR Unit continued to manage and support Technical Working Groups as a forum for partnerships and networks among and between organizations to share lessons learnt and best practices, strengthen coordination to reduce duplication and maximize impact and facilitate dialogue between duty bearers and rights holders.

Enabling Environment and Human Rights Technical Working Group (EEHRTWG)

Three (3) EEHRTWG meetings were held in 2017 with multi-sector stakeholders to:

1. Develop a stakeholder S&D Collaboration Map indicating the S&D activities being implemented across the national SRH response and identifying opportunities for collaboration.
2. Present the preliminary recommendations and findings of a review of HIV related S&D training processes to enhance the capacity development of health care workers in Jamaica.
3. Disseminate and explore programme implications from the preliminary S&D Baseline Assessment results emanating from a study conducted by Health Policy Plus, MOH and NFPB. The study was titled *"Supporting the HIV response in Jamaica through understanding and responding to stigma and discrimination in selected health facilities"*.

The EEHR TWG in session

Youth and Adolescent Technical Working Group (YATWG)

In 2017, the strategic focus of the Youth and Adolescent Technical Working Group (YATWG) was advanced through a two-day capacity building workshop held from May 27 to 28, 2017, with youth leaders drawn from the YATWG and the Jamaica Youth Advocacy Network (JYAN).

The primary objective of the training was to increase participants' knowledge and awareness of sexual reproductive health and rights through their engagement in evidence-based dialogue around the contentious issues of access to SRH information, products and services by minors and the human rights perspective. Among the outcomes of the training was the development of a roadmap for the engagement of high-level leaders in follow up discussions.

HUMAN RIGHTS AND POLICY MONITORING

In 2017, a partnership was forged between the NFPB and the Caribbean Vulnerable Communities Coalition to develop and validate policy monitoring tools to assess the quality of HIV-related treatment, care and support services provided at treatment sites across the island. Notably, two (2) Scorecards were developed to assess the implementation of the MOH's "Test and Treat" Guidelines, which were rolled out in January 2017. While both Scorecards were created to assess the delivery of ART services, one Scorecard focuses on service delivery to new patients, while the other focuses on existing and specialised categories of patients. Coming out of the validation process which also happened during the year, it was agreed that the Scorecards should be updated in 2018 to address additional needs of vulnerable populations. The EEHR Unit will be responsible for roll out and monitoring.

Through funding provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria, the NFPB secured agreement with the Jamaica Employers' Federation to build the capacity of 20 MSM, PLHIV and CSW as trainers to conduct sessions with their peers in advocacy, legal literacy and employability skills (entrepreneurship, resume writing, interviewing skills, completing forms, basic computer skills). Additionally, during the year, human resource and project management skills training workshops were conducted for project staff and peer leaders of CSOs that engage with key and vulnerable populations.

During the year, the EEHR Unit maintained Greater Involvement of Persons with HIV/AIDS (GIPA) as an approach to empower PLHIV and affected key populations by building their capacity for meaningful involvement and participation in the response. The Unit finalised the revision of the Positive Health Dignity and Prevention (PHDP) curriculum for use with key populations through the GIPA Core Group; the second edition was published in August 2017 and launched in October 2017. Graduates conducted workshop sessions with over 160 HCWs using select PHDP modules. Additionally, 40 MSM were trained by GIPA in 2017 in aspects of PHDP, bringing the total number of MSM participating in PHDP workshops since 2015 to over 500. The MOH TCS Unit and 2 NGOs reported that they used the curriculum with their beneficiaries in 2017.

Through Collaboration with Health Policy Plus and The Jamaican Network of Seropositives (JN+), the GIPA Coordinator Mr. Ainsley Reid (4th from left) presented copies of the PHDP Curriculum (Second Edition) to representatives of the Ministry of Health, National Family Planning Board, and the Global Network of PLHIV (GNP+). Ms. Laurel Sprague, Executive Director of GNP+, (Centre) commended Jamaica on this landmark achievement for PLHIV contribution to the National Response.

The Unit scaled up GIPA activities in 2017 to support the deployment of Community Facilitators (CFs) by the Jamaican Network of Seropositives. The deployment of PLHIV as lay providers was piloted as an approach to involve PLHIV in the delivery of HIV and SRH services. With technical support from the TCS Unit and Health Policy Plus (HP+), the Unit facilitated dialogue among RHAs and JN+ that resulted in the further strengthening of the Community Facilitator deployment by JN+. One CF was stationed at JN+. The EEHR mentored the Facilitators and conducted a series of PHDP refresher training workshops for the CFs and their respective site-level supervisors. The engagement of CFs initiated the formal inclusion of PLHIV participation as lay providers in health systems. This resulted in the creation of various tools to strengthen peer support activities, as a precursor to the development and implementation of PLHIV Support Group Guidelines. The aim is to improve facilitation of peer-led PLHIV groups that help clients lost to follow-up to be retained in care and achieve viral suppression.

The EEHR Unit provided technical support to HP+ to conduct a review of the PHDP training framework and to develop a national PHDP Framework for Jamaica. The recommendations articulated a more robust approach to involve PLHIV in the delivery of HIV and SRH related services and improve patient outcomes.

NON-DISCRIMINATION IN HEALTH SETTINGS

In 2017, the Unit pursued several strategic actions that promoted the provision of non-discriminatory health services to all, particularly youth, women and key populations. A collaboration was forged with LINKAGES, a US Government implementing partner, to review past and present S&D Curricula and Training Workshops targeted at HCWs and recommended best approaches to develop and assess same. The primary objective of this exercise was to elicit and articulate specific and targeted recommendations that will inform training and future capacity development exercises delivered to HCWs aimed at reducing stigma and discrimination in health care settings. Additionally, the Unit promoted a Self-review tool to be used as a reference point in the preparing health care workers for training in how to respond to HIV-related stigma and discrimination. The tool provides useful information to assist in designing training and S&D reduction initiatives for all levels of health care staff.

An electronic poster (ePoster), with audio features, displaying the WRHAs' Charter of Rights and Responsibilities was launched on October 26, 2017 at the Cornwall Regional Hospital. Over 100 persons were in attendance including clients of the hospital, representatives of JN+ and staff of the WRHA and NFPB. The Charter sets out the rights and responsibilities of both the client and the health care facility. The ePoster was developed through the collaborative efforts of the Investigation and Enforcement Branch of the MOH, the EEHR, NFPB and the WRHA. Designed to increase awareness and accountability, the e-Poster will be piloted at Cornwall Regional Hospital, Montego Bay Type V, Savanna-la-mar Public General Hospital, Falmouth Hospital and Noel Holmes Hospital. Smart televisions and jump drives were issued to these facilities for use in broadcasting the ePoster.

In October 2017 the NFPB handed over smart televisions to display the e-Posters

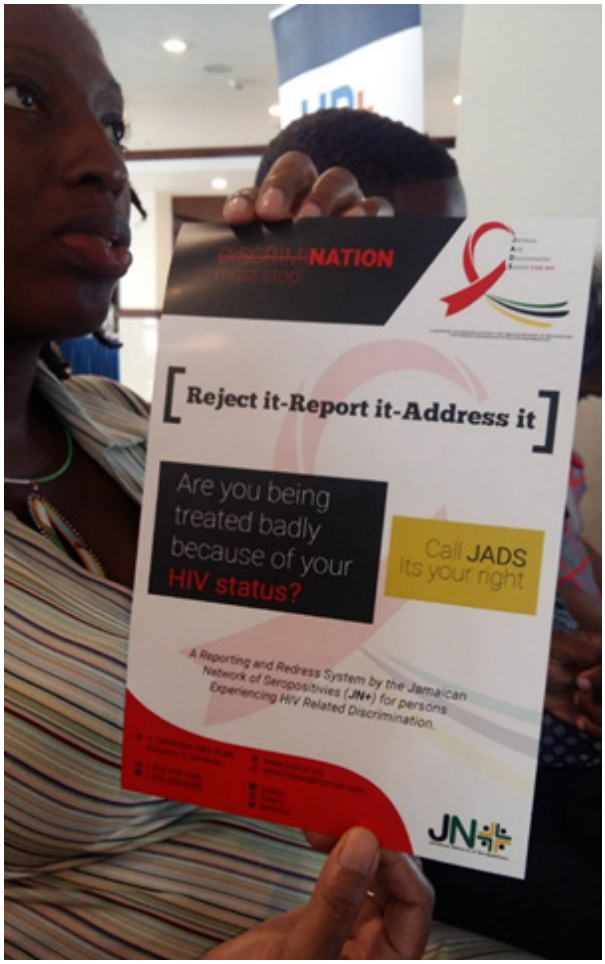
The Unit supported the Regional Health Authorities in the development of orientation training material and toolkits on agreed modules. The NFPB provided oversight to develop and finalise a training manual and toolkit, with specific modules addressing stigma and discrimination within public health facilities, targeted at new and existing staff. This was part of an initiative which began in 2015 to revamp the WRHA's orientation programme and implement a pilot project from which best practices could be identified and exported to other Regional Health Authorities. The manual is envisaged as an integral tool in developing a human rights culture to mitigate the various interpersonal challenges that are currently being experienced within the public health facilities. During the year, eight (8) consultations were conducted among stakeholders including frontline health care workers, senior managers, supervisors in the health care sector, key population groups and members of WRHA's Discrimination Reduction Steering Committee which includes representatives from the MOH, NFPB, WRHA and civil society organisations.

The Unit collaborated with the Western Regional Health Authority to develop a staff orientation training manual to help build capacity of staff around issues of diversity, dignity and human rights- based approaches to service provision.

During the year, the EEHR Unit also facilitated negotiations, dialogue and consultations to establish a formal referral mechanism between the RHAs, CSOs, Religious Groups and Social Service Support Providers. The Unit led consultations among technical, medical and non-medical teams including primary and secondary HCWs from the Regional Health Authorities and groupings of key populations and PLHIV; a total of 67 persons were reached through this initiative.

REDRESS FRAMEWORK IN ALL SETTINGS

During the year, the National HIV-Related Discrimination Reporting and Redress System (NHDRRS) underwent a restructuring process aimed at improving the efficiency of the redress system. The rebranded Jamaica Anti-Discrimination System for HIV was launched on November 10, 2017. The launch was an excellent opportunity to raise awareness and promote redress. As part of the restructuring process, the following actions were taken to improve the efficiency of the system:



1. JN+ hired two additional Redress Officers resulting in a marked increase in the number of complaints received from 9 in 2015 to 31 in 2016 and 47 between January and October 2017.
2. Chaired by the NFPB, the JADS Steering Committee established the Case Review Panel with a revised mandate and Terms of Reference.
3. The Steering Committee and the NFPB developed new standard operating procedures and policies to ensure more efficient and effective management of the System by JN+.
4. JN+ linked JADS to the Shared Incident Database, which electronically documents and monitors complaints; this was done to ensure that all complaints are tracked from receipt to redress and to provide more accurate data management and reporting.
5. The Steering Committee commissioned a renaming and rebranding process to increase awareness of the HIV-related redress system and to generate use of the system by affected persons.

In 2017, the Unit spearheaded four (4) redress consultations to solicit feedback from multi-sector stakeholders, including key government representatives and CSOs, to inform the development of a comprehensive Redress Framework, of which the JADS is one aspect. The consultations provided an opportunity to: 1) explore the provision of redress under the proposed Occupational Safety and Health (OSH) Act for incidents of workplace-based HIV-related discrimination; 2) increase awareness of the redress system at the community level, by mobilising participants from SDC-based community groups and engaging them in dialogue on the provisions of the System and 3) examine how the National HIV/AIDS Policy forms part of the legislative framework for the provision of redress in cases of HIV-related discrimination.

Through the Global Fund grant, the Unit maintained partnership with the MLSS during the year to support the Voluntary Compliance Programme among private sector employers. A Project Officer was assigned to the HIV Unit of the the Occupational Safety and Health Department of the Ministry and is responsible to provide strategic interventions with private sector workplaces while Ministry moves the process forward to enact a comprehensive OSH legislation for the entire Jamaican workforce. Recognizing that the passage of the draft OSH Act into law may take some time, and that several workplace safety and health concerns, including HIV, now require urgent attention, a programme of voluntary compliance to prepare enterprises for the key requirements under the draft Act was initiated. In 2017, a combination of assessments, audits and enrolments were performed with fourteen (14) corporate entities.

The MLSS and stakeholders exploring the provision of redress under the proposed OSH Act for incidents of workplace-based HIV-related discrimination.

The MLSS, supported by the Global Fund grant, hosted series of Legal Literacy Trainings from September 13 to October 30, 2017 in Kingston, Manchester, St. Ann and St. James. The workshops facilitated interactive discussions, between MLSS staff and members of the Industrial Disputes Tribunal, around strategies for addressing HIV and AIDS related issues such as terms and conditions of employment, labour laws/policies and anti-discrimination. A total of 115 MLSS employees were engaged during the five (5) workshop sessions. Participants explored adaptation options, planning strategies, application of existing procedures for operation and management and appropriate application of the National Workplace Policy on HIV and AIDS within a legislative framework.

CHALLENGES

- Sustaining civil society participation in EEHR led initiatives was challenging; the Civil Society Advocacy Plan was not finalized to articulate civil society priorities and concerns. Representation by civil society on working groups was not high level or consistent and some civil society partners did not actively contribute to the collaboration mapping exercises.
- Stigma and Discrimination among key populations continued to be a barrier to recruiting and securing commitments for greater involvement from key populations.
- High personnel turnover among health care players reduced the impact of interventions.
- Despite the scale up of efforts to sensitise PLHIV and KPs to customer service principles and the reporting and redress mechanisms, the number of documented complaints to the HIV-related discrimination reporting and redress system was suboptimal.

THE WAY FORWARD

Moving forward, the EEHR Unit will maintain its mandate to design and coordinate sexual and reproductive health strategies and interventions that promote a supportive environment facilitated by policies, programmes and legislation wherein all Jamaicans, including persons with HIV, youth and other vulnerable populations are socially included and their human rights protected.

In pursuit of this objective the Unit intends to focus on the following strategic priorities in 2018:

1. Work through the Youth and Adolescent Technical Working Group to develop, implement and monitor HIV and SRH policies and protocols to support adolescents and youth. In particular, the unit will pursue collaborations and partnerships that promote and expand access to SRH information and address and reshape social norms that support risky sexual behaviours and unplanned pregnancies.
2. Foster the creation of a more enabling workplace environment for key populations. In order to address the unmet needs for these marginalized communities, the Unit will, among other things, partner with the MLSS to pursue the support of the International Labour Organization to engage a consultant to develop the confidentiality protocol and the process flow chart for the management of HIV related workplace complaints.
3. Collaborate with LINKAGES Jamaica to study internalised stigma among MSM and TG persons in order to better plan, programme for and target these groups with information on family planning/reproductive health, HIV/AIDS and STIs.
4. Collaborate with Health Policy Plus (HP+) to facilitate and train health care workers at selected public health facilities in stigma and discrimination reduction strategies

geared towards improving service delivery and further enabling universal access to HIV and SRH services for key and vulnerable populations at those institutions.

5. To pursue efforts, as part of NFPB's overarching objective to enhance engagement of the general population, to reduce gender based violence (GBV) and encourage health care facilities to address the immediate needs of victims of GBV by training health providers to recognize signs of violence against women and girls, assess women's risk of violence and provide women-centred care.

6. Improve programming at public health facilities for delivery of SRH services for men. This would include the development of a Guide for Promoting Sexual and Reproductive Health Products and Services for Men that focuses on meaningfully engaging men and creating an enabling environment to increase men's use of SRH products and services.

7. Strengthen the Technical Working Group mechanism to accomplish more targeted and focused policy and advocacy across disciplines outside health sector and HIV centric civil society partners.

8. Coordinate the final deliverables to enable the revision of the National HIV Policy.

9. Develop a national PHDP framework for people living with HIV or AIDS in Jamaica and guide its full integration into the national response.

10. Collaborate with Youth and Adolescents Technical Working Group to identify advocacy initiatives to promote the delivery of SRH services to adolescents and youth.

11. Expand policy advocacy to remove the Legislative and Policy Barriers to integrated health and social development. A critical element of this approach will be joint advocacy with the Office of Public Defender and the Civil Society Joint Advocacy Forum for the promulgation of Anti-Discrimination Legislation in Jamaica.

CHAPTER 6: STRATEGIC INFORMATION

OVERVIEW

As the overarching goal to end the HIV epidemic emerged and the work of the HIV/STI/Tb Unit expanded, the need for a more comprehensive approach to data capture, analysis and use became increasingly critical. The National HIV/STI Programme needed a strategic information component that exceeded the boundaries of monitoring and evaluation to include surveillance, research and health information systems. The move from Monitoring and Evaluation to Strategic Information was undertaken during the year.

The SI Unit collects, analyses and disseminates data that is used to evaluate and expand the efficiency and appropriateness of programmes, which are aimed at prevention of HIV transmission, early detection of new HIV infections and treatment of HIV infected individuals. The NHP relies on the SI component to shape its objectives, inform and improve strategy and programming and monitor progress through research, analysis and forecasting. Programme Managers, policy-makers and stakeholders rely on quality information to make informed decisions that are in the best interest of the people and groups they serve. The SI component enables the NHP to respond proactively to the epidemic.

SURVEILLANCE

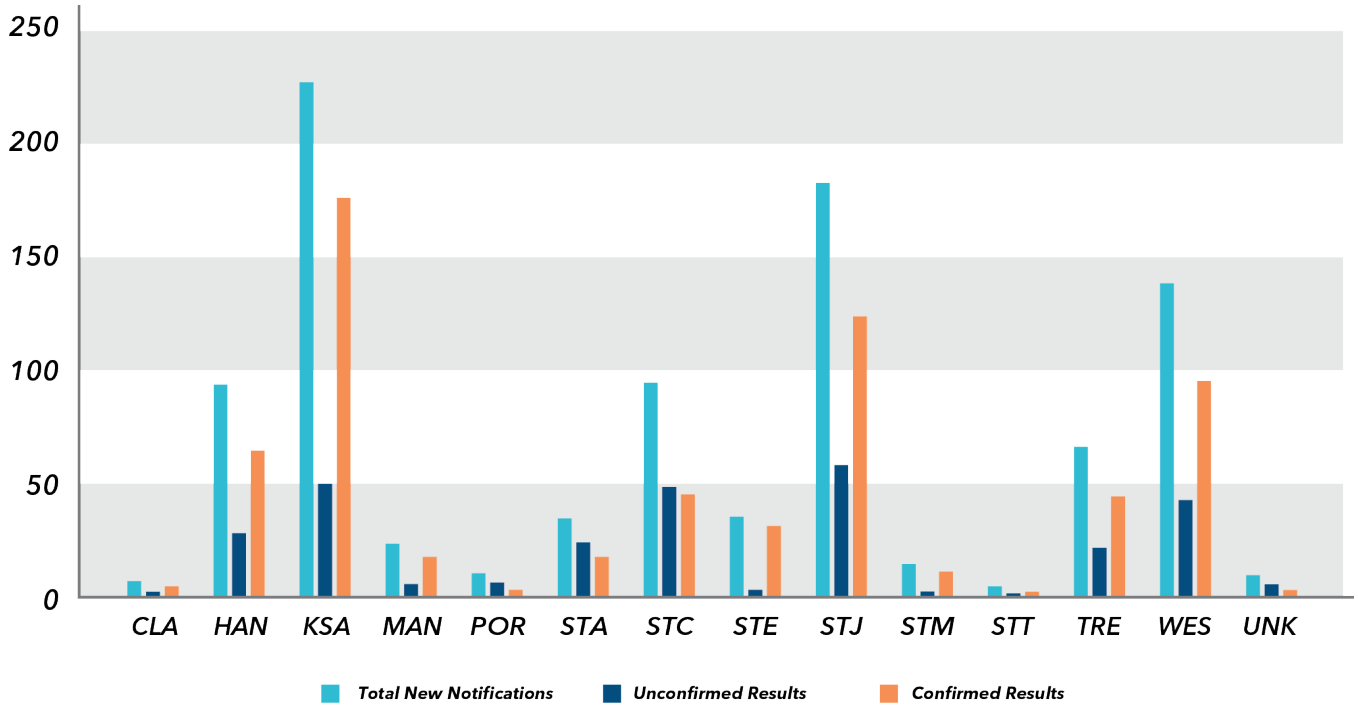
In collaboration with the Surveillance Unit, the SI Component monitored HIV, STIs, Tb, Hepatitis B and Hepatitis C. In 2017, the HIV case-based surveillance system resulted in the submission of 3,792 Class 1 notifications and confidential reporting forms to the MOH (Table 10). Of these, 950 were notifications with 641 confirmed cases. Further investigation is being done on the remaining 309 suspected cases, and generally on all cases, to determine the number of new infections for the year.

Table 10 HIV Surveillance log

NO. OF NOTIFICATIONS	NO. OF NOTIFICATIONS CONFIRMED	NO. OF NOTIFICATIONS NOT CONFIRMED (SUSPECTED)	NO. OF CONFIDENTIAL REPORTING FORM (CRF)	NO. OF PERSONS WITH CRF AND NOTIFICATIONS	NO. OF PARISHES REPORTING
950	641	309	2,842	230	14

The Class 1 notification reporting by parish is depicted in the graph below.

Fig. 18 Class 1 Notifications and Confirmed Results by Parish, 2017



Hepatitis & Tuberculosis

Hepatitis monitoring showed an increase in the number of cases in 2017 compared to 2016; there was a 100% and 325% increase in the number of Hepatitis B infections and Hepatitis C infections, respectively. There is currently no National Hepatitis Programme.

Tuberculosis on the other hand has shown a marked decrease of 41% in the number of cases in 2017 compared to 2016. Actual numbers can be seen in the table below.

Table 11 Hepatitis and Tb Surveillance

YEAR	HEPATITIS B	HEPATITIS C	TUBERCULOSIS
2017	54	13	62
2016	27	4	105

Sexually Transmitted Infections

In 2017, a total of 42,235 cases of STI was reported to the MOH; the majority (85%) of these were infections associated with genital discharge. Compared to 2016, there was a 3% decline in the total number of STIs reported and this decrease was noted in all categories of STIs.

HEALTH INFORMATION SYSTEM

Improving the health information system is critical to achieving epidemic control. This need resulted in the design of two electronic databases that allow individual patient tracking from outreach testing through treatment to viral suppression. Designed in 2016, the two DHIS2 web-based databases, for HIV treatment and HIV prevention services were officially rolled out in 2017; dubbed the Treatment Services Information System and the Prevention Services Information System (PSIS), respectively. These databases were implemented to ensure the production of clean de-duplicated data in real time to allow analysis, dissemination and usage of reliable information in decision-making.

Prior to the general use of the PSIS, training workshops were conducted at the National Family Planning Board. Additional workshops were subsequently held. All regions and outreach teams commenced use of the system by September 2017.

The TSIS was piloted in the Comprehensive Health Centre, Jamaica AIDS Support for Life Kingston Office and National Chest Hospital in the first half of the reporting year. Regional training workshops were also conducted prior to the general use of the system. By August, the system was rolled out in all the treatment sites. Training workshops were also conducted at the site level.

The databases replaced the stand-alone systems, which were not linked or accessible from

a central location. With the introduction of the new system, which provides data at the national level, the Unit has been able to generate timely reports to local and international stakeholders.

Jamaica's efforts toward elimination of mother-to-child transmission status must be supported by reliable data. A new database, which was designed for the Prevention of Mother-to-Child Transmission programme was implemented during 2017. This web-based database, which is available at all PMTCT sites, allows data to be quickly captured at the national level. This means that challenges faced at local PMTCT sites, that can affect our elimination status, can be met with an immediate national response.

All viral Load samples collected throughout the island are processed centrally at the National Public Health Laboratory. In the past, patient care has been hampered by delays in the return of viral load results using the paper-based system. In 2017, this was rectified by the merger of the TSIS with the NPHL database. This merger occurred in August and resulted in viral load results being immediately available in TSIS and notably, at the fingertips of the treatment teams dispersed throughout the island.

RESEARCH

In 2017, four research activities were conducted: Bio-Behavioural Surveillance Survey of Female Sex Workers, Bio-Behavioural Surveillance Survey of Men who have Sex with Men, the HIV Sentinel Survey and the Knowledge, Attitude, Behaviour and Practices Survey.

The FSW Survey was conducted among Female Sex Workers, Female Patrons and Workers of Sites where Persons Meet Sex Partners or Participate in Sexual Activity in Jamaica. This study determined the prevalence of HIV and Syphilis and the risk behaviours among FSW, patrons and workers at the sites where people meet sex partners to guide programme interventions for these group. The study was conducted from August to November 2017 and included all four health regions.

Data collected for the *Integrated Biological and Behavioural Surveillance Survey with Population Size Estimation among Men who have Sex with Men and Transgender (TG) Persons in Jamaica* began in December 2017. The study will be used to estimate the size of the MSM, TG population and to determine HIV prevalence and risk behaviours for these groups.

The *Annual HIV Sentinel Surveillance Sero-survey* was conducted in sentinel sites from three urban parishes and three rural parishes from all four health regions. This survey is used to determine the prevalence of HIV in the general population and at-risk populations. This survey includes STI clinic attendees and antenatal care clinic attendees.

The *Knowledge Attitude Behaviour and Practice Survey* was conducted over a six months period beginning in August 2017. The survey aimed to track the attitude and behaviour of the public to the HIV/AIDS epidemic as well as to monitor the impact of current interventions. Data was collected island-wide from a cross-sectional, household-based, survey among randomly selected sample of 2,000 persons aged 15-49 yrs.

MONITORING AND EVALUATION

Monitoring is an ongoing process of data collection and analysis, which allows assessments of the various activities and interventions undertaken by the Programme. It aims to track performance and improve the decision-making process that guides all projects. This function is undertaken through site audits, supportive supervision and data extraction from the electronic HIV prevention and treatment databases. The existing databases allow extraction of reports that reflect prevention outreach activities targeting key populations. Testing data is de-duplicated, a process that is facilitated by the unique identifier code (UIC) that is produced by the database. This allows individual tracking of clients being tested and their movement, if tested positive, through the continuum of care.

The treatment database strengthens monitoring through the available reports generated at the national, regional and site levels. These reports allow monitoring of:

- PLHIV who are lost to follow-up, so they can be identified in the community setting and returned to care.
- PLHIV who are defaulting so interventions can be done to prevent lost to follow-up.
- PLHIV who are retained in care and their ART status to ensure all clients are initiated in keeping with 'Test & Start' initiative.
- PLHIV on ART to ensure suppression.

THE WAY FORWARD

The Unit achieved some significant milestones during 2017, notably in research and health information systems. In 2018 the Unit will continue to deliver on its mandate to collect, analyse and convert data into sound, reliable information for decision-making. Toward this end, building the capacity of the team to execute its functions more effectively and efficiently will be a key focus going forward.

The Unit will conduct a 12 Component M&E Assessment to assess the current M&E System and provide a roadmap to benchmark progress made and identify gaps and areas in need of system strengthening. The findings of this assessment will serve as a platform for the development of an *Integrated Monitoring and Evaluation Plan (2019 - 2024)* which will be aligned to the National Integrated Strategic Plan.

The year 2018 will see more improvements to databases to enhance functionality, greater collaboration with health planners and decision-makers, more research activities and ongoing work to improve data quality, timeliness and relevance; these are all building blocks of any successful HIV/STI Programme.

One of the database improvements will be a merger of the HIV/AIDS Tracking Database, a repository for all diagnosed cases in Jamaica and the Prevention Services Information System, the repository of people reached and tested in community settings, with the Treatment Services Information System, allowing monitoring of PLHIV from diagnosis to

viral suppression.

The Treatment Services Information System, which was developed in 2016, will be upgraded to a new platform with enhanced security features and better data visualization tools. Currently, treatment data for PLHIV linked to care is only captured within the public sector. A collaboration with the private sector is expected to produce a private sector database on the new platform like TSIS. This will further aid the NHP in monitoring the epidemic and intervening for control by 2030.

Even though the MSM study will span the year 2018, there will be another research focusing on ART outcomes, which will assess the factors contributing to treatment failure, loss to follow-up and mortality. The outcome of these studies will improve programme planning and decision-making and impact the quality of care given to PLHIV in Jamaica.

The need for quality data cannot be overemphasized. Toward this end, the Unit will be embarking on a major data cleaning initiative to ensure that all data captured in its databases is correct, complete, consistent and useable. This will be augmented through continued data audits to identify and correct gaps in data collection and reporting. Additionally, improvements in the M&E capacity of staff at the regional, parish and site level will be prioritized through the specialized training activities focusing on data analysis and use.

CHAPTER 7: GRANTS MANAGEMENT

OVERVIEW

The national HIV/AIDS response is funded primarily by the Government of Jamaica, the Global Fund to Fight AIDS, Tuberculosis and Malaria and the United States Agency for International Development. The Ministry of Health is the Principal Recipient (PR) of the funds and the HIV/STI/Tb Unit, which exists within the MOH is the Project Coordinating Unit (PCU) for the national response.

Jamaica receives funds under the GF New Funding Model (NFM) Grant, titled "Support to the national HIV/AIDS response in Jamaica" and under the PEPFAR/USAID grant titled "Threats to the Environment and Citizen Vulnerability Reduced – Prevalence of HIV/AIDS in Key populations reduced".

Both international donors, the PEPFAR/USAID and GF, 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.

The funding received from all three entities supports the main components of the HIV/AIDS response, which include:

- Treatment, Care and Support
- Prevention
- Enabling Environment and Human Rights
- Monitoring and Evaluation
- Governance and Programme Management

FUNDERS

Global Fund

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 Grant

The reporting period January to December 2017 is the second of a three (3) year performance period based on the Grant Agreement signed with the Global Fund. Under the NFM, there are 19 Implementing Stakeholders – four (4) Sub-recipients, six (6) Sub sub-recipients, three (3) Implementing Partners and six (6) other Implementing Stakeholders. The pace of implementation of some activities were affected by challenges in recruiting and retaining staff and in identifying suitable candidates for consultancies. Lengthy procurement processes and under-estimation of the time required to execute studies continued to impact the timely completion of activities during the second year of the grant.

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.
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
- Female sex workers
- Transgender people
- People living with HIV
- Homeless drug users
- Youth and adolescents, within the key populations and PHLIV

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 MOH represents the government and is responsible for the management of the grant and ensuring the planned results are achieved.

USAID Grant Cycle

The USAID grant cycle has 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

The PEPFAR/USAID grant implementation period is October 2016 to September 2017. The total amount approved for this implementation grant period was US$3.1M. Although the implementation period commenced October1, 2018, the first tranche was disbursed to the MOH in the later part of January 2017. The lengthy delay in finalizing the work plan and the subsequent late disbursement of the funds created a level of uncertainty among the staff of the implementing entities. This affected their ability to effectively plan and execute activities in a timely manner. As a result, the entities were unable to successfully liquidate the funds and implement all their activities within the implementation period. The MOH requested and received approval for a six (6) month "no cost" extension until March 2018.

Objective 1: To support key population groups (MSM and SW) and PLHIV in accessing Combination Prevention, improve retention in the clinical cascade and reduce barriers to access and retention in care.

Objective 2: To support health systems strengthening and the capacity of stakeholders (KP, PLHIV, CBO/NGO and government) to improve programme and policy outcomes through the use of strategic information.

CONTRACTS AND AGREEMENTS

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 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
PEPFAR /USAID	October 2017 – September 2018	Select Parishes and treatment sites PLHIV, MSM, FSW	US$3,100,000	Funding agreement signed for 1 year and based on availability of funds
GOJ	Unlimited	All	J$ as approved in the Estimates of Expenditure (GOJ) Budget.	As donor funding decrease, GOJ continuously increases its contribution

Overview of the Partners

The Country representatives signing the agreements 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 (MoFPS) as well as by Jamaica Country Coordinating Mechanism (JCCM) members (the Chair & NGO representatives).

The USAID grant agreement is signed by the MOH and the Ministry of Finance and Public

Service (MoFPS). Following this process, the MOH signs an implementation agreement with the implementing stakeholders. The grants are performance based hence the amount of funds disbursed to the country is associated with 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	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 Programme 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 to the MOH via processing of Withdrawal Applications.
The Ministry of Health	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) which includes the response 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 of representatives from all stakeholders involved in 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 overseeing 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. Refers 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

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

- Global Fund 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	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 & Support
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
		CHARLES(SR)	TCS

GRANT MANAGEMENT UPDATES

- ***Technical Reports:*** Over the period, the implementing partners have shown improvements in completing the technical and financial reports correctly. The PR continued to work on a one-on-one basis with entities. The PR would like to acknowledge the SRs and implementing entities for their commitment and efforts to submitting the financial and technical reports on time.

- ***Risk Management:*** Based on the 2016 audit findings report, the PR submitted a detailed Audit Action Plan to the MOH Permanent Secretary (PS) and the GF. Over the period, the PR submitted quarterly updates on the progress of implementation of the Audit Action Plan to the PS and GF. During the third and fourth quarters, the PR intensified its site visits and provided technical support to all implementing stakeholders as they implemented their corrective measures. All entities submitted their Audit Risk Mitigation Plans to the PR. The relationship between the PR and the SRs have improved as they work together to improve their communication and internal controls mechanisms.

- ***Financial and Procurement Management:*** During year 2 of the NFM Grant, the changes implemented to enhance Financial Management and improve internal controls resulted in improvements in the quality of records maintained at the field level. The PCU and Sub-Recipient Operations Manuals and revised reporting templates were institutionalized and are in active use by stakeholders. There were improvements in the timely submission of reports. Disbursement of funds to SRs is now better streamlined and there is a clearer understanding of the forms to be completed to facilitate the process. The challenges in the recruitment and retention of suitable staff, consultants and suppliers resulted in a delay in the timely completion of deliverables and activities within the year 2 grant implementation period.

- ***Accounting System Upgrade:*** At the HSTU, the Accounting Software - ACCPAC/Sage 300 was upgraded during 2017, to include revised Chart of Accounts and redefinition of reporting templates, which are now fully designed. The roll out of the system required a huge investment of time with the same complement of staff who have also conducting more site visits. This approach placed constraints on staff and resulted in delays, which impacted the timely entry of accounting transactions.

- ***Health Information Systems Strengthening:***

    - DHIS2 treatment database was installed in all thirty-eight (38) treatment sites, with thirty-three (33) sites regularly utilizing the system. The remaining five (5) treatment sites have internet connectivity issues.

    - DHIS2 prevention database was installed in all outreach sites. A few of these sites are also experiencing internet connectivity issues.

- ***GF Mission:*** During the year, the GF Country Portfolio Manager and an M&E Specialist

attended the HIV Annual Review as well as met with the PS and CCM members.

- ***WAMBO:*** The MOH used WAMBO twice to procure ARVs and lubes. The first procurement was lengthy due to changes in staff at the PR and the newness of the process. However, the second process was timelier. In both cases, there were delays in deliveries as the ETAs were not met. Additionally, it was found that the overall cost of procuring through WAMBO PPM resulted in a budget overrun due to a higher than budgeted unit cost for one ARV and additional PSM costs (PSA fees, Insurance Buffer etc.) which are related to the WAMBO process. The additional cost was covered by efficiencies. A change of Customs Broker also resulted in overruns on the amounts allocated for in-country clearance and services charges.
- ***Human Resources:*** It has been a challenge to find suitable candidates to fill the position of Adolescent Psychologists.
- ***MOH Restructuring:*** The restructuring process within the MOH accounted for lengthy delays in receiving approval for documents. These delays impacted the timely implementation of programme activities and hindered the effective management of the grant.

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. The de-duplication process has had a negative effect on the morale of the outreach staff and the working relationship between implementing entities, as is expected when a new system is implemented.
2. Finding, reaching and testing new MSM continue to be a challenge as the implementing entities try different strategies to identify hidden MSM. Unfortunately, strategies like peer links and lymes are not always effective and have their limitations. During lymes, KPs will attend but not all are willing to be tested. The success of peer links is dependent on the size of peer networks. Hence, after a few months, some peer links have no new MSM to link. The sexual networks also overlap and result in duplication.
3. The crime and violence impacted negatively on the achievement of reach and test targets in the Western region and some parishes in the South East region.
4. The unavailability of lubes to distribute with the condoms limited comprehensive prevention services being offered to the KPs. It is anticipated that the lubes will be available for the next implementation period, as USAID has agreed to assist with providing supplies. A lengthy procurement process is expected in this regard.

5. The recruitment and retention of suitable peer links continued to be a challenge for implementing entities.

6. It is extremely difficult or even impossible to effectively conduct follow-up sessions with MSM who give incorrect or incomplete personal information because they want to remain hidden.

EEHR

1. It takes a long time to receive approval for the implementation of interventions involving health care workers or that require input from the Regional Health Authorities.

2. The successful implementation of these types of activities is heavily dependent on the availability of key stakeholders and their willingness to complete follow-up actions. Attempts to address the issues include early engagement of decision-makers and ensuring their involvement in the design, planning and implementation stages.

3. Stigma and Discrimination among PLHIV and key populations continued to be a barrier to the recruitment and securing of commitments for greater involvement of PLHIV and key populations, e.g. fear of involuntary disclosure through peer groupings or by association.

TCS

1. The delay in the timely completion of the 'Test and Start' campaign was as a result of the lengthy process to confirm key stakeholders' availability and involvement in the launch.

2. The implementation of the PLHIV peer facilitator pilot project was delayed due to the lengthy process to finalize the concept note and the candidate selection process.

3. Some clients are unwilling to access services outside of the public health system; appointments for referrals are not kept or the process is not completed.

4. The case management training was not implemented because the development of the curriculum took longer than expected.

5. Internal and external stigma continue to prevent PLHIV and KPs from participating in activities that are specifically designed for them.

6. Efforts to increase RTC can be daunting because contact information for some patients is not up to date; the telephone numbers are no longer in service and the home addresses are either incorrect or persons have moved to another location.

7. The hiring of consultants continues to be a lengthy process, as suitable candidates, with the requisite skills to conduct research or studies, are limited and often unavailable.

MER

1. Connectivity and limited internet access at some of the treatment and outreach sites delayed and/or disrupted the roll out of the DHIS2 database.
2. Data entry is sporadic in some entities because of the absence of a data entry clerk. This has led to limited ownership and monitoring of the databases at the site level.

SUCCESS STORIES & THE WAY FORWARD

1. **Partnership between the government and civil society.**

   A major strength of the response is the collaboration and partnership between the government and civil society entities. The multi-sectoral response is evident at the national and site levels where multi-sectoral committees and technical working groups are established to manage the design, planning, development and implementation of all major events and innovative interventions.

   Efforts to strengthen the collaboration and referral mechanism between CSOs and the RHAs will be scaled-up. This will help to reduce the time it takes for the RHAs decision-makers and implementers to buy-in and support collaborative interventions with CSOs. It will also reduce the time it takes to successfully implement interventions.

2. **PLHIV Facilitators**

   The engagement of PLHIV Facilitators to provide one-on one support to their peers at the treatment sites, and work as members of the treatment team, is one innovation that has the potential to increase the number of clients who adhere to their treatment and eventually become virally suppressed.

   Additional PLHIV Facilitators will be engaged to work with their peers at the treatment sites to expand the service and increase coverage.

3. **Safe Spaces and Facilities**

   The expansion of safe spaces and facilities has assisted in improvements to the quality of service and care provided at the site level.

   The expansion of retrofitted containers and other safe spaces at the site level will continue. The expansions will reduce some of the barriers caused by the limited infrastructure and provide more private spaces for clients and HCWs to interact.

4. **Case Management Approach**

   The case management approach has helped the workers at the treatment sites to work better as a team. Teams engage a collaborative approach to reviewing, assessing, facilitating and coordinating care for each client resulting in the best suited treatment

team member(s) being assigned to guide and assist individual PLHIV cases.

The scale-up of the case management approach to ensure that clients receive quality services and care from entrance to exit of the health facilities is critical to the response. This includes continuous training and the use of the data to make strategic decisions on how to improve and/or expand the services offered at the site level.

5. **Treatment Site Mentoring Team**

The implementation of the Treatment Site Mentoring Team to conduct audits, provide recommendations on corrective measures and provide technical support to the treatment team has been helpful in addressing some critical gaps at the site level.

The team will increase their site visits and provide technical support to ensure corrective measures are implemented in a timely manner. They will also ensure that improvements are properly documented.

6. **Peer Navigation System**

The Peer Navigation System has facilitated the link between HIV prevention and treatment; PLHIV and KPs are navigated to reach and be retained in care and treatment services.

In an effort to scale-up the Peer Navigation System, the Navigators will participate in the treatment team meetings and receive training in the case management approach.

CHAPTER 8: PROCUREMENT

OVERVIEW

In 2017, the Procurement Unit continued to lead in the strategic procurement of third party goods and services, delivering the best value and quality, in accordance with the GOJ Handbook of Public Sector Procurement Procedure (revised March 2014). The activities of the Unit are underpinned by the fundamental principles of public sector procurement: accountability, competition, economy, fairness, integrity, openness and transparency. During the year, the Unit focused on developing and strengthening its involvement with and support of internal and external customers/partners. This move allowed the Unit to gain a better understanding of customer/partner needs and consequently make recommendations to improve procurement management processes and enhance the skills of the people involved.

Substantial progress was made in enhancing procurement processes through ongoing site reviews and training at both government affiliated entities and NGOs. Going forward, activities will be geared towards results and performance, streamlining internal processes, strengthening capacity building and leveraging resources for service delivery.

PROCUREMENT THROUGH THE GOJ & DONOR MECHANISM

Government of Jamaica

Procurement processes using GOJ resources was significantly improved through better forecasting and earlier commencement of major procurement processes, for example procurement of ARVs. Assessments of stock levels are ongoing, and projections of needs were done well in advance of the fiscal period holding the funding to allow sufficient time for processing at the various procurement committees. During 2017, there were no major delays with any of the committees (Evaluation, Procurement, Goods Specialist Sector Committee and Cabinet) that impacted drug procurement or created a threat of stock outs.

Donor

Procurement activities are also guided by the donor agencies procurement guidelines and checklists. Open competition was emphasized as the basis for efficient and effective public procurement and the most suitable method for conducting procurement activities was selected.

A major development concerning donor agencies procurement within the year was the introduction of WAMBO, the Global Fund online procurement platform. Two instances of procurement for the National HIV Programme was undertaken using the platform; this was for the purchase of ARV drugs and test kits. The use of the platform was intended to secure better prices and minimize the length of time it would ordinarily take to buy these items through the standard process. There were some minor challenges using the platform and delays with delivery. However, the overall procurement time frame remains shorter than the standard GOJ process.

Zero-Rating of Suppliers Invoices

The HSTU faced challenges in getting zero-rating approvals returned from Tax Administration Jamaica (TAJ) in a timely manner using the online portal. This situation has since been improved through better communication with the TAJ and lobbying with our internal customers to ensure that suppliers' invoices meet all the necessary requirements. The assignment of TAJ Customer Service Representatives to MOH has also helped to keep the HSTU updated and abreast of applications for zero-rating.

IMPROVING PROCUREMENT EFFICIENCY

E-Procurement System

Some 2,000 persons, including procurement practitioners and suppliers, were trained during the year. 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 an electronic procurement management information system that facilitates audit, as well as the extraction of data, for statistical purposes.

Although the Procurement Unit commenced using the E-Procurement System in 2017, the wider HSTU has not been trained and hence full integration of the system within the Programme has been delayed. No timetable has been established to date for delivery of training to the team.

Goods Specialist Sector Committees

Following from the July 2016 commissioning of the five new Special Committees by the National Contracts Commission, the HSTU utilized the Goods Specialist Sector Committee in 2017 to receive approval for the procurement of Viral Load Tests, Reagents and Supplies valuing over JMD 60M. This new system is notably more efficient; the HSTU had access to specific persons on the Committee, which made for easier communication and faster processing time.

CAPACITY BUILDING

During 2017, the Unit conducted training workshops in Procurement Management for both project staff and implementing partners. The training delivered covered areas like: procurement policies and procedures, procurement planning, managing suppliers and review of audits findings with recommendations of required actions to mitigate against their reoccurrence. Some of the topics covered included developing specifications, preparing Request for Quotation (RFQ) documents and applying the public procurement guideline to the process as required by the Operations Manual. Standard templates were re-distributed as reminders. The workshops were designed to enhance the skills and competencies of officers supporting the procurement function in the various entities.

Site audits were also conducted quarterly to assess compliance, governance and risk management. Relevant feedback and recommendations were shared with each entity, and then formally dispatched, for the requisite actions to be taken.

CHAPTER 9: FINANCE & ADMINISTRATION

FINANCE

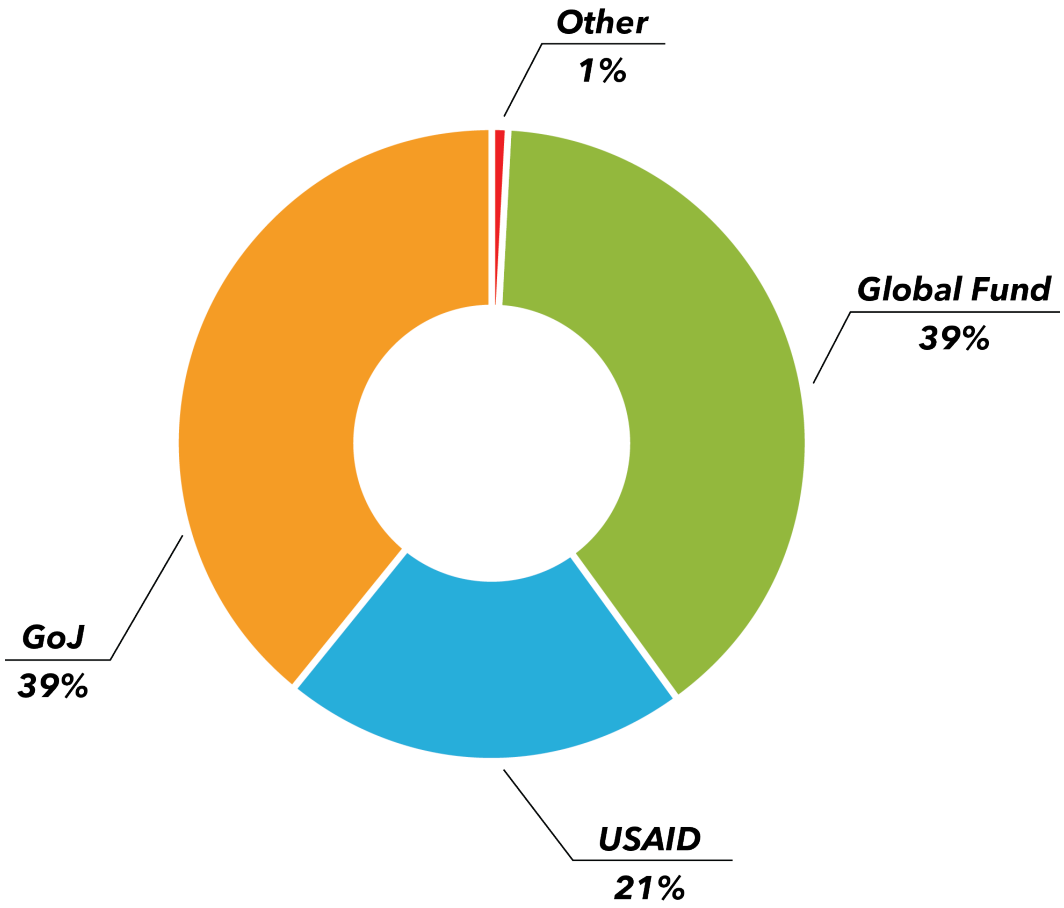
Overview

The objectives of the National HIV/STI/Tb Programme are primarily guided by the National Integrated Strategic Plan for SRH and HIV and specific objectives of Vision 2030 Jamaica, the National Development Plan. A substantial portion of the funding for the HIV/AIDS response has been supported through agreements with donor agencies such as Global Fund New Funding Mechanism and United States Agency for International Development. However, contributions from the Government of Jamaica have increased significantly since 2013, representing an investment in a more sustainable national response.

The budgetary contribution for the HIV/AIDs response in 2017 was J$1.95B; this represents an approximately 16% (J$269M) increase over the previous year. The largest increase was in the Global Fund contribution (18% or J$132.84M). The total GOJ contributions through the recurrent budget and through its contribution towards the USAID & Global Fund grant funded projects was J$765.38M. The GOJ's contributions in 2017 increased by 19% or J$118.84M, making the GOJ the largest overall contributor by a slight margin, over the Global Fund. Resources were also received from the GOJ through in-kind contributions.

The Global Fund New Funding Mechanism, which was signed in 2016 was in the second year of implementation and contributed 39% of the budget (J$762.31M). This is an increase of approximately 21% over the previous year. Under USAID, the Year 7 agreement (532-IL-532-HE-DOAG-000005) was signed in the amount of US$3.1M; this grant is expected to end in September 2018. Operating concurrently during 2017 was Year 6 Implementation Letter (IL) 4 (532-IL-532-HE-DOAG-000005); this grant had an originally end date of September 2017, however, it was extended to March 2018. The Programme also received J$0.11M in small grants from UNICEF.

Fig. 19 Budgetary Contribution by Calendar Year 2017



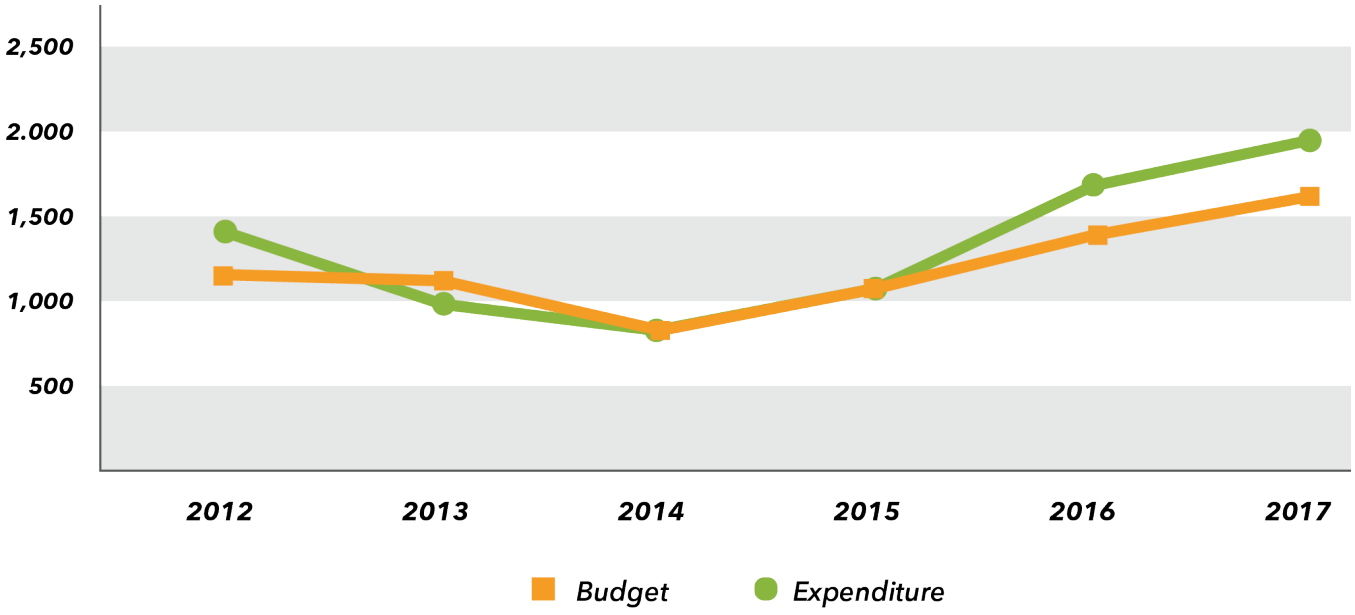
Source: National HIV/STI Programme Financial Statements

Expenditure

The budgeted expenditure for 2017 was J$1.95B; 83% (J$1.62B) of this amount was spent. Of the total expenditure for the year, the Principal Recipient was responsible for spending 45% (J$573.38M) while 55% (J$629.48M) was spent at the Sub-recipient level. The main areas of under-expenditure relate to the GF NFM Grant as delays were experienced in the finalization of external consultancies and the settling of invoices for ARVs procured through WAMBO. Savings were also realized from the GOJ contribution made through the Global Fund Grant.

Over the years, there have been fluctuations in the amount of resources made available to the Programme, but expenditure was largely equivalent to the resources received (Figure 21). However, in 2016 and 2017 expenditure was lower than projected by J$286M and J$331M, respectively. The analysis was done using calendar year figures in keeping with the requirements of the Annual Report. The cash basis of accounting is applied in the Programme.

Fig. 20 National HIV/STI Expenditure by Calendar Years, 2012-2017



Source: National HIV/STI Programme Financial Statements

The Programme has several components, expenditure in these areas are detailed in the remainder of this section.

Prevention

The National Family Planning Board is the technical lead for all prevention interventions for the national response. In 2017, the budget for prevention activities was J$400.48M. This allocation was approximately 23% lower than the amount allocated in 2016. The Prevention Unit expended J$359.08M or 90% of its budgeted allocation.

Most of the resources of the component are being expended at the SRs level; activities are aimed at reducing the spread of HIV and target most at-risk populations and the general population. The work of the Unit entails targeted interventions for MSM and FSW populations, peer education, procuring of condoms and lubes, procuring HIV test kits and training and capacity building for CSOs that are implementing prevention activities. Costs related to staffing, travel assistance/stipend and support for certified skills training for vulnerable groups were supported by the component. Significant work was also done by the Prevention component for the Adolescent group; funding for this was provided through the Global Fund, USAID and UNICEF.

Treatment, Care and Support

The TCS component of the national response is focused on ensuring that there is a comprehensive system of care for PLHIV. Over the years TCS was allotted with the largest portion of the Programme resources; 2017 was no different with the introduction of the 'Test and Start' initiative. A total of J$864.14M was allocated for year which represents an increase of J$106.96 or 14% over the allocation made in 2016. The TCS Unit expended J$740.70M or 86% of its budgeted allocation.

During the year, the Unit continued to support the national response by providing ARVs, test kits, reagents, alternative nutrition for new-borns of HIV infected mothers and other medicinal supplies required by the Programme based on available funding. Other initiatives undertaken during the year was the strengthening of the case management protocol and adherence counselling efforts, monitoring and preventing ARV resistance and improving the standardized method of tracking adherence and ARV resistance. Other expenditures were mainly from the GF NFM Grant resources. One of the major challenge faced during the year under the component was the reduction in the GOJ contributions through the recurrent budget.

Enabling Environment/Advocacy & Policy

The NFPB is the technical lead for the EE&HR/Advocacy and Policy Component. During the year, significant worked was done through Jamaica AIDS Support for Life (JASL). In 2017 J$82.67M was allocated to the component; this was an increase of 76% over the previous year. The component expended 86% (J$71.07M) of its budgeted allocation. Funding for the component was made available largely through the USAID and Global Fund NFM resources.

The component continues to work actively to reduce stigma and discrimination. During 2017, focus was placed on implementing strategies to achieve an effective redress framework. This involved facilitating stakeholder involvement, developing and implementing policy and protocols on referral mechanisms and training and sensitizing key populations.

Strategic Information

In 2017, J$67.62M was allocated for surveillance, monitoring and evaluation and research. The component spent J$40.60M (60%) of its budgeted allocation; J$17.27M more was spent in 2017 than in the previous year.

Strategic Information is a critical to the national response. The component is tasked with the responsibility of collecting, collating and analyzing all the data in support of targets and indicators for the Programme. A major achievement during the year was launch of Treatment Site Information System using the DHIS2 platform. The component continues to train the out stations in the use of the DHIS2, which links the database at all the treatment sites throughout the country for HIV patient management, to ensure that information is being captured timely and accurately. The component continues to face challenges with unique identifier code and TSIS in that, there are confidentiality concerns surrounding the database configuration. Also, some sites are having connectively issues when trying to access TSIS. One major activity that was not done during the year was the completion of the Human Rights Baseline Assessment, which was being supported through the Global Fund resources.

Capacity Building/Administration

The successful implementation of the Programme activities is achieved through the people and the tools that are in place to support the work to be done. Twenty-eight percent (28%) of the annual budget was allocated to this component in 2017. The mandate of this component was also achieved through training and capacity building activities for the staff.

In 2017, J$516.99M was allocated for Capacity Building/Administration, of which J$409.58M (79%) was spent. Both the budgeted allocation and expenditure for 2017 was higher than the previous year; the additional funding was made available from the GOJ resources. The majority of the spending occurred in the following areas: staffing, administrative fees for the SRs, audit costs, site reviews for SRs and workshops.

The diagram below shows a comparison of budgeted and actual expenditure for the components over the years 2014 – 2017.

Table 16 Comparative Summary of Component Expenditures, 2014 - 2017

COMPONENTS	CALENDAR YEAR 2014		CALENDAR YEAR 2015		CALENDAR YEAR 2016		CALENDAR YEAR 2017	
	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	329.17	311.15	288.79	285.01	520.29	441.01	400.48	359.08
Treatment Care & Support	175.00	189.41	368.02	345.03	757.18	656.68	884.14	740.70
Monitoring & Evaluation	23.68	30.56	38.47	33.75	63.21	23.33	67.62	40.60
Capacity Building/ Administration	247.38	236.16	334.50	384.42	295.25	227.61	516.99	409.58
Enabling Environment/ Policy	62.95	44.03	54.81	62.14	46.91	44.16	82.67	71.07
Sub total	838.19	838.32	1084.60	1100.34	1682.84	1392.79	1961.90	1621.08
In Kind Contribution		73.35		80.69		68.59		379.92
Grand Total	838.19	911.67	1084.60	1181.03	1682.84	1461.38	1951.90	2000.95

Funding Sources

Global Fund NFM Grant

Funding from the Global Fund NFM Grant, which commenced in 2016 is in its second year of implementation. It is slated to end in December 2018. The total value of the grant is US$15.24M. The main goals of the Global Fund NFM Program are as follows:

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

The resources of the Program were primarily used for the procuring of ARVs, testing supplies, condoms, staffing (especially at the SRs) and scaling up of prevention and advocacy activities. With the approval of the reprogrammed budget for year 2 (2017), the funding allocation was J$762M, of which J$589.85M (77%) was liquidated. From the unliquidated variance of J$172.47M, J$86.53M has been committed to: finalize outstanding administrative fees to NGOs; salary costs; payments for ARVs processed through WAMBO; support the payment of consultancies relating to the Audit Fees; Human Rights Baseline Assessment and FSW and CSW surveys.

USAID/PEPFAR

During 2017, the USAID PEPFAR grant contributed J$415M to the Programme budget, this is a 5% (J$19.47M) increase in the amount budgeted over the previous year. Expenditure for the year was J$413.40 or approximately 100% of the annual budget. The resources for the grant agreement spans two financial years; as the USAID financial year runs from October to September, the budget and expenditure relates to USAID YRs 6 & 7, which were being managed concurrently during the reporting period. The resources of the project were used to achieve two main objectives under Year 6 and Year 7:

Year 6

- To support key population groups (MSM and SW) and PLHIV in accessing Combination Prevention, improve retention in the clinical cascade and reduce barriers to access and retention in care.
- To support health systems strengthening and the capacity of stakeholders (KP, PLHIV, CBO/NGO) and government through use of strategic information to improve program and policy outcomes.

Year 7

- To increase treatment coverage in Jamaica so that 75% of diagnosed PLHIV are on treatment and 80% of PLHIV on ART achieve viral suppression by the end of FY 19;
- To improve data access, quality and use, particularly for KP.

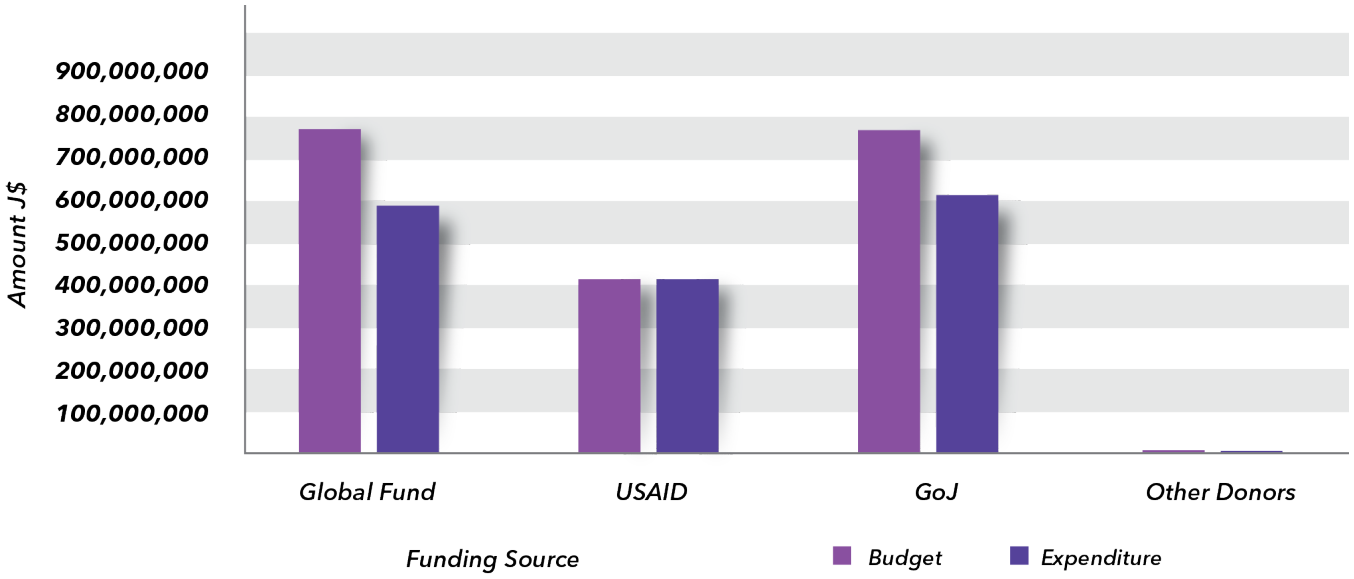
Government of Jamaica

The GOJ contributed 39% of the cash resources of the Programme during the year. This was made available through the recurrent budget and contributions to the USAID and Global Fund Grants. In 2017, the GOJ contributed J$765.38 when compared with J$646.54 in 2016. The Programme liquidated 80% (J$613.01M) of the GOJ's allocation. A significant portion of this funding was used to cover staff cost; J$263.37M of the total expenditure for the year related to human resources.

During the year, the Programme benefited from in-kind contributions, from the Government of Jamaica, valued at J$379.92M. These contributions include salaries, office space rental and maintenance, security and janitorial services.

The diagram below shows an analysis of the budget and expenditure for the respective funding sources during 2017.

Fig. 21 Budget vs Expenditure by Funding Source, 2017



Challenges

During the year, the Programme was faced with several challenges. These include:

- The significant reduction of the recurrent budget under object 25.
- Not receiving warrants in a timely manner after projections are submitted to the FAD for the recurrent budget.
- Frequent adjustments to the budget and reallocations both at the PR and SR levels under the USAID Grant.
- Scheduling conflicts, between capacity building activities and the school schedule, as it relates to the UNICEF resources. This resulted in delays in the timely liquidation of the resources.
- Changing of the reporting template and method for the Global Fund Progress report as at December 2017.
- A shortage of human resources which created a backlog in the Unit. Finance staff had to increase monitoring of the SRs while managing the day to day operations of their individual desks.

Despite these challenges the Unit was able to submit on-time quarterly Progress Reports to the Global Fund and the Expenditure Analysis and Financial Audit to USAID. The Unit was able to increase monitoring and assist in strengthening internal controls within the PR and SRs. Unqualified audit opinions were received from both the USAID and Global Fund grants during the year.

Appraisals

The close out financial audit for the period April 2016 to March 2017 for USAID was due on December 31, 2016. The draft report was shared with USAID as per the due date. However, the signed report was submitted later. The audit was conducted by BDO audit firm.

The Global Fund audit, which covers the period January to December 2017, is due to the Global fund on March 31, 2018. 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.

ADMINISTRATION

Overview

The Administration Component leads the human resource management and administration functions of the National HIV/STI Programme. The Component plays a key role in supporting and strengthening stakeholders both at the HSTU and field levels as well as streamlining the planning of major activities.

Staffing

Grant funding and GOJ contribution, approved and included in the Government of Jamaica 'Estimates of Expenditures', supported approximately 150 officers across the public sector and non-governmental organizations (NGOs) working in both technical and administrative areas. Within the 2017 calendar year, 12 new officers were on-boarded at the Head Office while 2 officers resigned. At the field level there were challenges with the identification and retention of some key experts such as Case Managers, Psychologist, Peer links, Adherence Counsellor and Procurement Officers, owing to the specialized skill set required to work with key populations and an unattractive compensation package. Active steps were taken to address the latter through approvals sought from our donors. At least eighty-five (85%) of all vacancies within all partner organization were filled as at the end of 2017.

Some key vacancies were filled within the year including four posts within the newly formed Strategic Information Unit, formerly Monitoring and Evaluation, which is responsible for collating, analysing and disseminating reliable data for decision-making within the National HIV/STI Programme. This restructuring was implemented during the year in response to the need for strategic information that exceeded the boundaries of monitoring and evaluation to include surveillance, research and health information systems.

The Treatment Component was restructured to include a Clinical Mentor, an additional Programme Development Officer and a Pharmacist. All the vacancies in the Unit were filled, except for the Pharmacist position which was still vacant at the end of year. In 2017, a process also commenced to re-activate two GOJ positions. This is a collaborative process with the HR Department within the Ministry and remains a work in progress at the end of the calendar year.

The Administrative Unit played a key role for contract officers and SRs and in some case facilitated gratuity payments for staff. Active follow up was done with the various internal departments of the Ministry as well as individuals entities. Mechanisms are being streamlined to strengthen the efficiency of the process. The recommendations of the internal auditor's report are being implemented as far as is practicable.

With the push to transition from donor funding to domestic reliance, one of the missions of the HSTU is to ensure the full integration and absorption of staff within and by their respective entities. Efforts will be revisited within the upcoming calendar year to collaborate with our Government affiliated partners to map out their sustainability cost, gradual/progressive absorption by their home entity over time and support of their efforts to incorporate their programme cost including HR costing in their budgetary submissions to the Ministry of Finance and the Public Service (MoFPS).

Team Meetings

In 2017, the Administrative section of the HSTU coordinated and hosted a total of five (5) Administrative Regional Team Meetings with the Regional Health Authorities and non-governmental entities. Components of the Programme involved in these administrative meetings were Finance, Procurement, Grants Management and Human Resource & Administration. The ART/ANT meetings were designed to provide the teams with an avenue to discuss the challenges and best practices in administering grant resources at the site level. Some of the key areas highlighted during the meetings held in 2017 were maintenance of human resource files, audit findings and how to mitigate them, understanding and application of the procurement guidelines, grant updates and progress of technical deliverables. The meetings provided a forum to build capacity and share information across entities and an opportunity to understand the site-level issues that have the potential to delay Programme implementation and identify mitigating strategies. Ultimately, the aim is to deliver a high standard of administrative support to ensure the success of the National HIV/STI Programme.

Monitoring and Oversight

During 2017, there was an increase in monitoring and oversight to field stakeholders to review human resource records and practices and support related functions, such as recruitment of officers and/or providing the requisite document templates to ensure compliance. These visits were made mandatory as a strategy to mitigate against adverse audit findings in HR management and other areas. Written feedback and close out meetings enhanced the quality of files. Inroads were made in respect of corrective actions;

however, the site reviews still revealed some adverse findings in respect of adherence to internal controls and quality of records. It was also observed that there is a protracted delay in the implementation of recommended corrective actions at subsequent site reviews. Check-lists were developed and shared with the entities to guide the processes being undertaken. The HSTU continues to extend support to ensure that consistently high standards are maintained.

HIV Annual Review

The HIV/STI/Tb Unit held its 27th Annual Review and Planning Retreat from November 22 – 24, 2017, under the theme: "Navigating with Purpose: Examining the status of the National HIV Response and planning the way forward". The focus was particularly relevant as the national response sought to ensure that all Jamaicans access optimum healthcare in respect of their sexual and reproductive rights. The meeting served as a forum to review the national HIV response over the last calendar year, highlight best practices and explore ways to treat with the gaps in the response going forward. Two hundred and Fifty (250) participants, including representatives from the HSTU and the four Regional Health Authorities, National Family Planning Board, People Living with HIV/AIDS, non-government organisations, Ministry Departments and Agencies, the Joint United Nations Programme on HIV/AIDS, the United States Agency for International Development President Emergency Plan for AIDS Relief, the Global Fund to fight AIDS, Tuberculosis and Malaria and other international and civil society organisations were in attendance.

The event was coordinated by the Administrative Component with support from the Administrative Officers across the Programme.

Capacity Building

The Programme is vested in developing staff capacity to ensure that individuals have the skills they need to function effectively in the response. Budgetary support, through GOJ Object 29, 'Scholarship and Awards' facilitated training for officers at the RHAs and HST Unit. The topics included Training & Development, INPRI and Cabinet Submission and Drop box.

Notably, there are ongoing training opportunities within each component involving the HSTU and field officers for each specialized area. These are delivered in a classroom setting and on a one-on-one basis, as needed.

Office Space

Lack of adequate office space remained a challenge for the HSTU necessitating creative solutions to ensure adequate workspace for the team. Options for relocating staff and files to alternative spaces are being explored; financial support would be required.

New Initiatives

The Admin Corner

During the year, a monthly newsletter was created to inform and educate HSTU staff on key matters including: 1) management of attendance through proper use of the attendance register, which can impact timeliness and accuracy of gratuity payments; 2) content of health insurance plan and 3) new human resource and administrative procedures developed by the MOH.

HSTU Orientation Manual

During the year, the Unit developed an Orientation Manual with accompanying delivery schedule for new staff. New officers are now oriented on the operations of the Ministry of Health and the HSTU through formal orientation sessions using written manuals to ensure a seamless on-boarding process.

The Acquisition of Prevention Testing Units

The Administrative Component in conjunction with the Procurement Unit led the procurement/retrofitting of a coaster bus, which was assigned to the NERHA and SERHA. The bus will be used for Prevention and Treatment work within the respective regions.

HIV & AIDS FACTS AND FIGURES 2017

DATA TABLES

Table 1: Summary of HIV Cases Diagnosed by Year and Sex, 1982 - 2017

YEAR	MALE (%)		FEMALE (%)		UNKNOWN (%)		TOTAL
1982-1996	2770	62.7%	1613	36.5%	37	0.8%	4420
1997	698	60.9%	447	39.0%	2	0.2%	1147
1998	652	58.6%	460	41.3%	1	0.1%	1113
1999	831	56.0%	651	43.9%	2	0.1%	1484
2000	853	54.4%	714	45.6%	0	0.0%	1567
2001	795	50.0%	791	49.7%	5	0.3%	1591
2002	729	51.7%	681	48.3%	1	0.1%	1411
2003	844	50.1%	838	49.8%	1	0.1%	1683
2004	865	45.8%	1023	54.2%	0	0.0%	1888
2005	896	45.7%	1063	54.3%	0	0.0%	1959
2006	994	48.3%	1063	51.7%	1	0.0%	2058
2007	823	48.4%	879	51.6%	0	0.0%	1702
2008	944	47.5%	1040	52.4%	2	0.1%	1986
2009	798	48.2%	859	51.8%	0	0.0%	1657
2010	849	52.1%	782	47.9%	0	0.0%	1631
2011	823	49.2%	850	50.8%	0	0.0%	1673
2012	835	51.3%	793	48.7%	0	0.0%	1628
2013	680	53.7%	586	46.3%	0	0.0%	1266
2014	585	49.2%	604	50.8%	0	0.0%	1189
2015	543	51.1%	519	48.9%	0	0.0%	1062
2016	661	53.3%	580	46.7%	0	0.0%	1241
2017	621	51.9%	576	48.1%	0	0.0%	1197
Total	19089	52.2%	17412	47.6%	52	0.1%	36553

Table 2: Summary of Aids Deaths in Jamaica, 1982 – Dec. 2017

YEAR	MALE	FEMALE	TOTAL
1982-1996	768	428	1288
1997	248	145	375
1998	233	142	442
1999	341	207	538
2000	359	257	557
2001	329	258	616
2002	402	285	696
2003	380	269	677
2004	378	285	700
2005	306	203	548
2006	263	168	513
2007	202	117	293
2008	236	164	429
2009	234	143	390
2010	198	135	397
2011	234	158	342
2012	155	101	282
2013	169	129	159
2014	121	96	196
2015	136	118	136
2016	185	133	260
2017	170	139	293
Total	6047	4080	10127

Table 3: Summary of Aids Death by Parish in Jamaica, 1982 – Dec. 2017

PARISH	2017	1982 - 2017
Kingston & St Andrew	183	3850
St Thomas	3	124
Portland	2	215
St Mary	4	375
St Ann	9	449
Trelawny	6	310
St James	8	1622
Hanover	3	307
Westmoreland	7	673
St Elizabeth	5	286
Manchester	7	341
Clarendon	6	284
St Catherine	45	1265
Parish Unknown	5	19
Overseas address	0	7
Total	293	10127

Table 4: Rate of Persons Living with HIV/AIDS in Jamaica by Parish of Residence (2017 and cumulative)

PARISH	TOTAL HIV/ AIDS CASES	DEATHS AMONG PLHIV 1982-2017		TOTAL PLHIV	PARISH POP.	RATE PER 100,000 POPULATION
	1982 - 2017	N	Rate	1982 - 2017	STATIN	2017
Kingston & St Andrew	13056	3850	0.29	9206	670312	1373.4
St Thomas	614	124	0.20	490	95015	515.7
Portland	804	215	0.27	589	82710	712.1
St Mary	1203	375	0.31	828	114959	720.3
St Ann	2533	449	0.18	2084	174343	1195.3
Trelawny	1007	310	0.31	697	76043	916.6
St James	4799	1622	0.34	3177	185846	1709.5
Hanover	937	307	0.33	630	70322	895.9
Westmoreland	2081	673	0.32	1408	145746	966.1
St Elizabeth	968	286	0.30	682	151961	448.8
Manchester	1269	341	0.27	928	192036	483.2
Clarendon	1912	284	0.15	1628	247902	656.7
St Catherine	5018	1265	0.25	3753	521669	719.4
Parish Unknown	319	19	NA	300	N/A	N/A
Overseas address	33	7	NA	26	N/A	N/A
Total	36553	10127	0.28	26426	2728864	968.4

Table 5: HIV Seroprevalence (%) Among ANC Attendees by Parish – 2017

PARISH	TOTAL TESTED	TOTAL POSITIVE	% POSITIVE	(95% CI) EXACT
Kingston & St Andrew	1313	18	1.37	0.87 – 2.16
St Catherine	1,057	12	1.14	0.65 – 1.97
St Ann	523	2	0.38	0.05 – 1.37
Clarendon	803	2	0.25	0.03 – 0.90
St James	460	8	1.74	0.88 – 3.39
Westmoreland	610	1	0.16	0.00 – 0.91
Total	4766	43	0.90	0.67 – 1.21

Table 6: HIV Seropositive Prevalence Among STI Clinic Attendees by Parish – 2017

PARISH	TOTAL TESTED	TOTAL POSITIVE	% POSITIVE	(95% CI) EXACT
Kingston & St Andrew	1224	76	6.21	4.92 – 7.71
St Catherine	307	8	2.61	1.13 – 5.07
St Ann	181	3	1.66	0.34 – 4.77
Clarendon	82	1	1.22	0.03 – 6.61
St James	275	7	2.55	1.03 – 5.17
Westmoreland	34	2	5.88	0.72-19.68
Total	2103	97	4.61	3.76 – 5.60

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