

Revised National HIV Policy 2017, Jamaica

FIRST DRAFT



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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behaviour Change Communication
CBO	Community Based Organisation
CEDWA	Convention on the Elimination of Violence against Women
CSOs	Civil Service Organization
CSS	Community Systems Strengthening
CSW	Commercial Sex Worker
EEHR	Enabling Environment and Human Rights
eMTCT	Elimination of Mother to Child Transmission
FBO	Faith Based Organisation
FGM	Female Genital Mutilation
FSW	Female Sex Worker
GARPR	Global AIDS Response Progress Report
GIPA	Greater Involvement of People Living with HIV
GBV	Gender Based Violence
GDP	Gross Domestic Product
GFTAM	Global Fund to fight AIDS, Tuberculosis and Malaria
GOJ	Government of Jamaica
HAART	Highly Active Antiretroviral Therapy
HBC	Home Based Care
HCW	Health Care Worker
HIV	Human Immuno-deficiency Virus
HSS	Health Systems Strengthening
HTC	HIV Testing and Counselling
ICDP	International Conference on Population and Development
IEC	Information, Education and Communication
ILO	International Labour Organization
IOM	International Organisation on Migration
KAPB	Knowledge, Attitudes and Practices Behaviour Survey
LTIs	Life Threatening Illnesses
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MOH	Ministry of Health
MoT	Mode of Transmission
MoY	Ministry of Youth
MLSS	Ministry of Labour and Social Security
MSM	Men who have Sex with Men
MNS	Ministry of National Security
MSP	Multiple Sex Partnership
MTF	Medium Term Socio-Economic Policy Framework
MTCT	Mother to child Transmission
NAC	National AIDS Committee
NAP	National HIV/STI Control Programme
NFPB	National Family Planning Board



NGO	Non Government Organisation
NHP	National HIV/STI Programme
NSP	National Strategic Plan
OVC	Orphan and Vulnerable Children
OWG	Open Working Group
OI	Opportunistic Infection
OSH	Occupational Safety and Health Act
PAC	Parish AIDS Committee
PANCAP	Pan Caribbean Partnership Against HIV/AIDS
PEP	Post Exposure Prophylaxis
PIOJ	Planning Institute of Jamaica
PLHIV	Persons Living With HIV
PLWHA	People Living With HIV and AIDS
PMTCT	Prevention of Mother To Child Transmission
PWD	Persons with Disabilities
RHAs	Regional Health Authorities
SDG	Sustainable Development Goals
SH	Sexual Health
SRH	Sexual Reproductive Health
STATIN	Statistical Institute of Jamaica
STI	Sexually Transmitted Infection
TWGs	Technical Working Groups
UNDP	United Nations Development Programme
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational Scientific & Cultural Organisation
UNICEF	United Nations Children's Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation



FOREWORD



1 INTRODUCTION AND BACKGROUND

1.1 Context

Jamaica is the largest English-speaking Island in the Caribbean region with a land area of 10,991 square kilometres and a total population of 2,714,734¹. The island is divided into 14 parishes. The capital city, Kingston on the southeast coast and the city of Montego Bay on the north coast are the two-main urban centres. Jamaica is currently at an intermediate stage of the demographic transition. It has a declining 0-14 age group (9% of total population); an increasing working age group of 52% and a dependent elderly population comprising 11.9% of the total population. A significant proportion, 25% of the population resides in Kingston, the capital city.

Jamaica's epidemiological profile is marked by a declining burden of communicable diseases and a considerable increase in non-communicable diseases. Recent national surveys among adults aged 15-74 years of age show an upward trend in the prevalence of overweight and obesity, hypertension and diabetes.

These surveys show that obesity, hypertension and diabetes affect approximately 50%, 25%, 10% and 10% of the adult population, respectively.² Of increasing importance is the co-morbid impact of obesity, hypertension, cardiovascular diseases and HIV. HIV continues to play a significant role in the morbidity and mortality levels of the population and carries great financial and human resource cost to the health sector. HIV and AIDS rank among the top 10 causes of premature death in Jamaica. Moreover, the epidemic threatens national productivity because most of the cases occur in the reproductive and working age groups.

1.2 Background for Revision of the National HIV Policy

In 2005, Jamaica drafted its first National HIV Policy, 23 years after the first case of HIV was presented and three years into the country's first HIV/AIDS/STI Strategic Plan (2002-2006). The policy provided broad guidelines for the design, implementation and management of HIV and AIDS interventions, programmes and activities at various levels. The Policy established the foundation for guidelines and legislation to:

- Promote the health of the population, individual responsibility for health and the practice of healthy lifestyles.
- Protect the rights of people infected with and affected by HIV/AIDS.
- Reduce HIV/AIDS-related stigma and discrimination.
- Create an enabling environment for improved access to prevention knowledge, skills, treatment, care and support.
- Mitigate the socio-economic impact of the epidemic³.

It is now 35 years since the first case was diagnosed in Jamaica and the response to the epidemic has matured significantly since 2005. The progress that Jamaica through the HIV/STI/Tb Unit and the National

¹ Statistical Institute of Jamaica (STATIN) 2013 Population figures.

² Ferguson, TS. et al. National health surveys and health policy: impact of the Jamaica health and lifestyle surveys and the reproductive health surveys. *West Indian Medical Journal*, Mona, v. 61, n. 4, July 2012. Accessed at http://caribbean.scielo.org/scielo.php?script=sci_arttext&pid=S0043-31442012000400015&lng=en&nrm=iso. on May 15, 2015.

³ Ministry of Health. 2005. National HIV Policy



Family Planning Board – Sexual Health Authority continues to make in the HIV response has been significant. This has been possible through the continuous support, commitment and dedication from all key partners in the response to HIV and AIDS and SRH. The country has established strong linkages and partnerships with a wide range of partners from within and outside of Jamaica. Resources, though not adequate, have been mobilized and are available to fight the epidemic. The Government, international development partners and the Global Fund to fight AIDS, Tuberculosis and Malaria (GFTAM) have provided funding for the national response. The involvement and participation of Stakeholders' - (including non-governmental organizations (NGOs), people living with HIV and AIDS (PLWHA), civil society groups, faith-based organizations and the private sector) - involvement and participation in the response have also increased. This has allowed for cohesion and consensus on some of the critical issues and actions to be taken in the national response.

Jamaica is among countries globally that have seen a reduction in the number of new HIV infections since 2004, declining by 42%⁴ by 2012. By the end of 2015, there were 29,000 Jamaicans known to be living with HIV and AIDS. Of the estimated 29,000 persons living with HIV infection in Jamaica, 85% (24,650) have been diagnosed. This represents a major success in the testing capacity of the country since 2004.

Since 2004, there has been a consistent increase in the number of people on treatment. The statistics show that in 2016, 43% of those diagnosed were on treatment and 55% of those on treatment were virally suppressed.

AIDS mortality rate continues to trend down with just over 9 deaths/100,000 population in 2015. This represents a 64% decline since 2004 when the rate stood at 25 deaths/100,000 population.

The infection rates among sex workers have also shown reductions, falling from a high of 9% in 2004 to 2.9% in 2015⁵. There have been improvements in condom use among men who are in multiple partnership relationships and among sex workers and MSM. HIV testing has increased across all groups.

HIV prevalence among antenatal women has also declined over the last 15 years, with 2015 prevalence rate at 1%. In 2015, for every one thousand pregnant women attending public antenatal clinics, approximately 10 were HIV infected. The Prevention of mother-to-child transmission (MTCT) of HIV programme in Jamaica has been highly successful and Jamaica is on track to meeting the regional elimination goal of $\leq 2\%$.

Notwithstanding the positive developments highlighted, HIV prevalence remains at an alarming rate among some key populations, notably men who have sex with men (MSM) and transgender persons; deeply entrenched issues around stigma (both internal and external) and discrimination continue to pose a serious threat to the control of the HIV epidemic; the Knowledge Attitude Practice and Behaviour Survey (KAPB) 2012 shows worrying trends in condom use among youth and women; multiple sexual partnerships continue to be high and some myths appears to be re-emerging. This trend shows that the battle is yet a long way to be won, hence the need to scale up the country's efforts to end AIDS by 2030 and to revise the policy.

Other key developments in the response to HIV and AIDS have also contributed to the need for the revision of the HIV and AIDS Policy to more effectively deal with emerging issues and trends. These include:

⁴ Joint United Nations Programme on HIV/AIDS (UNAIDS). 2014. The Gap Report. Geneva, Switzerland

⁵ Ministry of Health, 2015. Jamaica Epidemiology Update



1. Since 2005, several other regulations, policies and plans relevant to HIV and AIDS have been implemented. Among the main policies is the **National HIV/AIDS Workplace Policy**. The National HIV/AIDS Workplace Policy was developed by the Ministry of Labour and Social Security and adopted as a White Paper by the Jamaican Parliament in February 2013. The policy provides guidelines for both the public and private, formal and informal sectors, to develop and implement HIV/AIDS workplace policies and programmes to protect workers living with or affected by HIV and AIDS.
2. **Integration of HIV and SRH:** There has been significant progress towards one national coordinating platform with the integration of the National HIV/STI Programme into the National Family Planning Board (NFPB) in 2013 to form one executive agency with responsibility for sexual and reproductive health. The National Family Planning Board, empowered by the National Family Planning Act (1970), is the Government agency responsible for preparing, implementing, coordinating, and promoting sexual and reproductive health services in Jamaica. In 2013 the Jamaican Government gave approval for the integration of certain components of the National HIV/STI Programme into the NFPB. The components that were integrated were:
 - Support to Treatment and Care Services
 - Prevention
 - Enabling Environment and Human Rights
 - Monitoring and Evaluation

The overall direction and leadership of the response currently lies with the Sexual Health Authority. It has the legal status and mandate to autonomously manage and coordinate the national response with formal reporting relationships to government authorities at ministerial and administrative levels.

The central Ministry of Health has retained those aspects of the former National HIV/STI Programme - now known as the HIV/STI/Tb Unit in the Ministry of Health - that currently focus on Policy, Treatment and Surveillance, Quality and Standard Setting.⁶

3. **National Integrated Strategic Plan for Sexual and Reproductive Health and HIV 2014 – 2019:** Since 1988, Jamaica has had a national plan to guide the response to HIV and a well-established National HIV/STI Programme. Revision of this strategic plan, which began in 2014 and was finalized in 2015, reflects the new integrated approach for sexual health services and now guides the joint delivery of family planning and HIV programmes in Jamaica. Sexual and reproductive health and rights – as part of inalienable human rights, forms the core emphasis of this National Integrated Strategic Plan for Sexual and Reproductive Health and HIV (2014-2019). The plan provides a blue print for achieving the vision of an integrated programme while supporting the achievement of the Sustainable Development Goals. Furthermore, the plan responds to the Government of Jamaica’s thrust to rationalize the public sector through the creation of a single sexual health authority.
4. **Test and Treat Policy:** In October 2015, the World Health Organization (WHO) issued guidelines on its ‘treat-all approach’ which essentially recommends antiretroviral therapy (ART) for everyone living with HIV at any CD4 cell count. Commonly referred to as ‘Test and Start’, the approach requires that persons are placed on ART immediately after an HIV-positive diagnosis to improve health outcomes. The National HIV/STI/Tb Unit began utilising the ‘Test and Start’ approach as a strategy to achieve the UNAIDS 90-90-90 treatment targets by 2030 in January 2017.
5. **Focus on Adolescent Sexual and Reproductive Health:** The National HIV/STI/Tb Unit has embarked on a strategy to address the sexual and reproductive health needs of adolescents under the global initiative “All In to End the AIDS Epidemic among Adolescents (ages 10-19) by 2030”.

⁶ UNGASS Report, 2016



This is a platform for action and collaboration to drastically improve the situation of adolescents through critical changes in programmes and policy. Jamaica is among countries globally that initiated actions towards improving the situation of adolescents in the context of HIV and AIDS. The main aim of All In is to accelerate reductions in AIDS-related deaths and new HIV infections among adolescents by 2020 as part of the global push to end the AIDS epidemic for all by 2030. The overall global targets for All In are a reduction by 75% the number of new infections and 65% reduction in AIDS-related deaths among adolescents. All In is an opportunity for Jamaica to improve data collection, analysis and utilization for programme planning for adolescents generally.

6. Gender integration and mainstreaming⁷ is an important aspect of the HIV response. The National HIV/AIDS Policy 2005 is not aligned to key international commitments vis-à-vis gender, gender equality and gender-based violence including the Montevideo Consensus; Convention on the Elimination of Violence against Women (CEDAW), the Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women (Convention of Belem Do Para); Beijing Declaration and Platform for Action and the International Conference on Population and Development (ICPD) Programme of Actions Policy. Statements tailored to meet the unique gender-specific needs and challenges of different beneficiary groups are necessary.

Issues pertaining to gender, gender-based violence and the disproportionate number of females vis-à-vis males who are infected are not fully articulated in the National HIV/AIDS Policy (2005). There has been a narrowing of the gap between new HIV cases among the genders with women now accounting for 46% of cases in 2012. Issues of gender inequality and sexual violence are recognised as the driving factors for the epidemic among females. Cultural norms and values shape negative gender relations that help drive the epidemic. Culturally, men have a large degree of control over women and prevailing values and norms uphold men's privileges and have tended to constrain women's autonomy.

Young females account for the greater share of HIV cases in the 10 – 29 age range. In the age group 15 to 19 years old, four times more young women have been reported with AIDS than young men. Similarly, young women aged 20 – 24 years old are one and a half times more likely to be infected than males in the same age group. The trend continues with those aged 25 – 29 years old, where women are 1.15 times more likely to be infected than men the same age⁸.

It is globally recognised that there is need to improve the way government entities work by ensuring that resources are used more effectively in implementing HIV policies and programmes to achieve the results needed on the ground. The current HIV Policy is not linked to the ongoing thrust of Results Based Performance Management in the Public Sector.

From a Results Based Performance Management perspective, the National HIV Policy should define overall goals and outcomes, and should be part of the legislative and regulatory framework that supports

⁷ The Beijing Platform for Action defines gender mainstreaming as: "...the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and at all levels. It is a strategy for making the concerns and experiences of different beneficiary groups of women and men an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated - the ultimate goal is to achieve gender equality."

⁸ Ministry of Health/National HIV/STI/TB Unit. 2015. HIV Epidemiological Profile 2015, Facts & Figures



the implementation of the National HIV Strategic Plan. The Policy should articulate key indicators and broad targets which will help to assess progress towards achievement of strategic goals and outcomes.⁹

The National HIV/AIDS Policy (2005) articulated a number of objectives and related strategies; however, the document did not designate responsibilities for ensuring achievements. For the HIV response to be given the special attention it deserves, this National Policy will demonstrate a renewed emphasis on evidence-based and data-driven programming and propose an active Monitoring and Evaluation Framework.

The National HIV/AIDS Policy (2005) was developed at a time when the epidemic was generalised. However, epidemiological data indicates that the country has a mixed epidemic, that is, while it affects the general population, there are pockets of concentration among certain groups. With new evidence from the Modes of Transmission (MoT) study (2012) and evaluations done by UNAIDS and the National HIV/STI Programme, it has become necessary to develop a HIV Policy that will guide the implementation of HIV interventions, based on the evidence now available, and especially among those key population groups that are most affected.

Developments at the global level also indicate the need for revision of the policy. Two of these are of importance.

90-90-90 Treatment Targets¹⁰: In 2014, the Joint United Nations Programme on HIV and AIDS (UNAIDS) launched the 90-90-90 Targets to end AIDS by 2030. The targets refer to three key steps that UNAIDS deem essential to both better health and care for HIV positive people and to limiting new infections and the further spread of the HIV epidemic. The targets are:

- a. By 2020, 90% of all people living with HIV should know their status.
- b. By 2020, 90% of all those who are diagnosed with HIV to be on sustained antiretroviral treatment (ART).
- c. By 2020, 90% of those on ART having an undetectable viral load.

The targets reflect a fundamental move in the global approach to HIV treatment, which involves shifting focus from the number of people accessing antiretroviral therapy and towards a focus on maximizing viral suppression among people living with HIV.

The Sustainable Development Goals¹¹: In 2015, the implementation period of the Millennium Development Goals (MDGs) came to an end. A new Sustainable Development Framework was adopted to cover the period of 2015-2030. Specifically, HIV and AIDS is covered under **Goal 3** of the SDG: Ensure healthy lives and promote wellbeing for all at all ages. The goal lays out nine targets to be achieved by 2030, including to:

- ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

⁹ The International Bank for Reconstruction and Development. 2007. Planning and Managing for HIV/AIDS Results A Handbook

¹⁰ UNAIDS, 2017. Ending AIDS - Progress towards the 90–90–90 targets.

¹¹ Interagency Coalition on AIDS and Development. HIV, Gender, Sexual and Reproductive Health Rights and the Post 2015 Development Agenda. January 2015. Accessed at http://www.icad-cisd.com/pdf/Publications/Post2015_EN-FINAL.pdf on May 20, 2015



- reduce global maternal mortality to 70/100,000 live births;
- end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable diseases
- research and development of vaccines and medicines, making full use of TRIPS flexibilities

In addition, Goal 5: Achieve gender equality and empower all women and girls' is relevant to the HIV response. It has proposed targets to:

- ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the ICPD and the Beijing Platform for Action and the outcomes of their review conferences;
- end all forms of discrimination, violence, and harmful practices against women and girls, including trafficking and sexual violence, and child, early and forced marriage and female genital mutilation (FGM)

1.3 National HIV Policy 2017

This document is the revised National HIV Policy for Jamaica and considers recent development in the national and global response to HIV and AIDS. The document provides the overarching policy framework, direction, guidelines, and general principles for interventions in prevention, treatment, care and support among those infected and affected by the epidemic.

The policy provides guidance on human rights and legal issues and supports an enabling environment for the national response. The policy therefore prohibits discrimination against persons infected or affected by HIV and safeguards the right to privacy and confidentiality subject to certain exceptions.

It directs actions towards mitigating the socio-economic impact of HIV on PLHIV, orphans and vulnerable children (OVC) and other key population and vulnerable groups. The policy addresses HIV-related stigma and discrimination, together with issues of gender, sexual orientation and the socio-economic status of the infected and affected. Key mitigation efforts include the reduction of stigma and discrimination against PLHIV, key populations and vulnerable groups. They also address the impact of HIV on households, especially women, children and the aged.

The policy outlines broad policy measures for the management and coordination of the national response. A key component is health systems strengthening (HSS). The policy seeks to ensure that key resources for HIV and AIDS are integrated within the health system to enhance overall efficiency.

The policy also promotes community systems strengthening (CSS). A strong and supportive civil society that works in tandem with the health sector will contribute to the sustainability of the HIV response.

Community systems strengthening in collaboration with health systems strengthening can influence prevention and treatment outcomes at the individual level as well as improve access to healthcare.

The policy recognises that research, monitoring and evaluation are important to the effective planning, co-ordination and implementation of the National HIV Policy and provides guidelines to address these.

This policy is applicable to both public and private sector entities, state and non-state actors and provides a platform for related legislation, strategic plans, implementation plans and HIV or SRH-specific standards, guidelines and protocols.



The National Policy is expected to evolve over time with new scientific knowledge, information and evidence. Changes in knowledge, attitudes, practices and behaviours are expected overtime, which would usher in revisions. Therefore, the policy will be revised every five years to ensure that they reflect the national needs and priorities as well as the changing face of international development.

This Policy is effective for the period 2016 – 2021.

The document is organised into 12 sections as follows:

- Section 1: Introduction and Background
- Section 2: Situational Assessment of HIV and AIDS in Jamaica
- Section 3: Policy Framework
- Section 4: Prevention of HIV Infections
- Section 5: Treatment, Care and Support
- Section 6: Enabling Environment and Human Rights
- Section 7: Mitigation of the Social and Economic Impacts of HIV and AIDS
- Section 8: Health System Strengthening
- Section 9: Community Systems Strengthening
- Section 10: Implementation Framework
- Section 11: Resource Mobilisation, Management and Monitoring
- Section 12: Monitoring and Evaluation



2 SITUATIONAL ASSESSMENT OF HIV AND AIDS IN JAMAICA

2.1 Epidemic Overview

Epidemiological data support the characterisation of the Jamaican HIV epidemic as being mixed as it exhibits features of a low-level generalised epidemic as well as a concentrated epidemic.

At the end of 2015, there were 29,000 Jamaicans known to be living with HIV and AIDS. Approximately 19% of Jamaicans are unaware of their status. Between January 1982 and December 2015, a total of 34,125 cases of HIV were reported to the Ministry of Health (MOH). The majority of persons diagnosed (72%) are still living¹².

Key populations that constitute the concentrated epidemic include female sex workers, men who have sex with men, transgender persons, homeless persons, and inmates. National surveys indicate that one out of every three (38.9%) men who have sex with men (MSM) is HIV-infected, 2.9% of female sex workers is HIV-infected, 3.3% of inmates are HIV positive and 4% of homeless drug users.

The key populations highlighted often overlap further complicating the epidemic. MSM that reported having received or paid cash for sex was 41%, notably higher than the overall prevalence in either the MSM or SW groups. Of the other underlying determinants identified from both MSM and SW studies, 15% of the MSM surveyed reported being homeless, 60% of sex workers used marijuana and 59% homeless persons reported other illicit drug use¹³. Age was also identified as an underlying determinant for contracting HIV. Among young MSM aged 15-24 years, the prevalence among those who engaged in sex work was 35.7%; and among other young MSM, the prevalence was lower, but still exceedingly high at 20.3%. Among FSW, the proportion of those with STIs (gonorrhoea, chlamydia or syphilis) was 20.2% among those aged 15 - 24 years compared to 15% in older FSW. Female sex workers with HIV and another STI was also higher at 6% among those aged 15 - 24 years than the older sex workers¹⁴.

Other epidemiology data for 2015 indicates that Jamaica continues to maintain serious epidemics of HIV and other sexually transmitted infections despite progress made in the last decade. The following are some of the major highlights¹⁵:

- As at the end of 2015, an estimated 1.6% of the population are living with HIV
- There were 1,222 HIV cases diagnosed and reported to the Ministry of Health in 2015. Data indicated that 67% of those diagnosed in 2015 were at stage 1 – HIV; 16% advanced HIV and 12% with AIDS. Notably, 5% of newly diagnosed cases were deaths. This means persons were only diagnosed in death. There was a decline in the percentage of persons diagnosed with AIDS in 2015 over 2014 when 16% were first diagnosed as AIDS. There were increases in both new HIV and advanced HIV cases in 2015 over 2014. In 2014, new HIV cases diagnosed was 66% and 13% for advanced HIV cases.
- Approximately 26% of all new AIDS cases occurred in the age group 20-29 and 70% among those aged 20-49. The distribution of the new epidemic has shown an increasing number of infections

¹² Ministry of Health, 2015. National HIV/STI/TB Unit Annual reports 2012 - 2015

¹³ Weir, S. JP. Figureoa, L. Byfield, C. Jones-Cooper, M.M. Hobbs, I McKnight. 2013. High HIV Prevalence among Men Who Have Sex with Men in Jamaica is Associated with Social Vulnerability and Other Sexually Transmitted Infections. The West Indian medical Journal (Impact Factor: 0.28). 01/2013; 62(4):286-91.

¹⁴ *ibid*

¹⁵ Ministry of Health/National HIV/STI/TB Unit. 2015. HIV Epidemiological Profile 2015, Facts & Figures



among women and in 2015, the male female ratio was 1:1. More than two-thirds of these cases (63.0%) were from three parishes – Kingston and St. Andrew (KSA), St. Catherine (STC) and St. James (STJ).

- As has been the case for decades, the leading modes of transmission among newly diagnosed cases in 2015 were persons with a history of sexually transmitted infections (STI) at 2.84% and multiple sexual partnerships. Further, among males, 9% of newly diagnosed cases were among MSM and among females, 3% were among FSW. Mode of transmission was not identified in 40% of newly diagnosed HIV cases among males.
- Between January 1982 and December 2015, 34,125 cases of HIV were reported to the Ministry of Health. Of this 9,517 (27.9%) are known to have died.
- Sixty-three percent (63%) of reported HIV cases in 2015 were from the most urbanized parishes (KSA, St. Catherine, and St. James). The most urbanized parishes have the highest cumulative AIDS case rates: Kingston & St. Andrew – 1,033.4 cases per 100,000 persons, and St. James – 1,515.2 HIV cases per 100,000 persons.
- HIV prevalence among young adolescent girls and boys aged 10-14 is equal and is estimated to be 0.1% predominantly the result of mother-to-child transmission of HIV (UNAIDS, 2014).
- Surveillance data from STI clinic attendees in 2015 indicated that for every 1,000 persons with a sexually transmitted infection, approximately 20 were infected with HIV.

2.1.1 GENDER

Females (613/50.2%) accounted for slightly more newly diagnosed cases than males (609/49.8%) in 2015. However, the cumulative male: female ratio for persons reported with AIDS in 2015 was 1.31:1, very similar to the ratio of men: women reported in 2014 (1.32:1). The cumulative AIDS case rates are higher among males (27.8 cases per 100,000) compared to females (21.6 cases per 100,000 females). Thus, although the epidemic affects more men than women, over time females are accounting for an increased proportion of the AIDS cases that are reported annually compared to the beginning of the outbreak.

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

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

In contrast with the estimated HIV prevalence of 0.4 and 0.5 reported in adolescent girls and boys aged 15 – 19 at the national level, some populations within the adolescent group are more affected. The HIV prevalence among gay and bisexual adolescent boys is estimated to be 14% while HIV prevalence in transgender adolescents is estimated to be 27% (National HIV/STI Programme, 2014) underlining the extreme vulnerability and urgent need for sustained HIV prevention, treatment, care and support response for these adolescents.



2.1.2 AGE

Three quarters (75%) of Jamaicans living with HIV are aged 20 – 49 years old. At the same time, about 26% of the HIV diagnoses made in 2015 were in Jamaicans between the ages of 20 and 29 years old.

Cumulatively, there is a steep incline in the number of AIDS cases from 10 – 24 years. The number of AIDS cases reported among 20-24-year olds (1,154) is over 4 times the number of cases reported among 15-19-year olds (261 cases) which may possibly be due to testing access.

2.1.3 TRANSMISSION, RISK FACTORS AND KEY DRIVERS

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

As has been the case for decades, the sexual practice of 41% of men ever reported with HIV (and 45% of men reported with AIDS) was unknown¹⁶. This is due to inadequate investigation and reporting of cases as well as unwillingness among men who engage in sex with other men to disclose their sexual practices. Of the total number of men reported with HIV in 2015, 5.7% (35) were identified as homosexual and 3.2% (20) identified as bisexual. In 2015, a total of 28 PLHIV (2.2%) reported being a sex worker, with the sex breakdown among them showing 64% (18) females to 36% (10) males.

Data on the HIV epidemic in Jamaica acknowledge the main risk factors fuelling the epidemic as: multiple sexual partners¹⁷; history of STIs, crack/cocaine use, and sex with sex workers. ‘No high-risk behaviour’ was reported for a significant proportion (12%) of HIV cases and this may represent persons who have one sex partner who was HIV infected by another partner.¹⁸

Other notable high-risk behaviours that are integrally linked to the main risk factors are insufficient condom use, early sexual debut, and transactional sex. Some of these factors are expanded further based on their ability to erase gains already made in the response to the epidemic.

Multiple Sexual Partners (MSP): This is the most immediate cause of new HIV infections and significantly correlates with the majority of drivers of the epidemic (MoT 2012, KAPB 2012). Implicit in the practice is the prevailing cultural norms about manhood and as such MSP is tacitly accepted in the Jamaican socio-cultural dynamic. Men are more likely to have multiple sexual partners than women – males report on average 6.2 women whilst women report having 2.2 (KAPB 2012). The Knowledge Attitude Practice and Behaviour (KAPB) Survey 2012 reported that 41% of sexually active persons aged 15 - 49 years who had sex in the last 12 months had sex with two or more partners. The data shows that 60.5% of males reported having multiple sexual partners compared to 19.4% of female respondents reporting having multiple sexual partners.

Insufficient condom use: Condom use is a proven measure of protection against HIV, but in general there are low levels of condom use. According to the KAPB (2012), due to increased risk perception, persons engaging in multiple sexual encounters seem more likely to use condoms. A total of 63% of Jamaicans

¹⁶ Ministry of Health/National HIV/STI Programme. (2015) HIV Epidemiological Profile 2015, Facts & Figures

¹⁷ This is generally defined as sexual behaviour characterised by having more than one sexual partner in the same time period.

¹⁸ Ministry of Health/National HIV/STI Programme. (2015) HIV Epidemiological Profile 2015, Facts & Figures



engaged in multiple sexual partnerships reported they used a condom the last time they had sex compared to 57% in 2008. The data show that of the 60.5% of males reporting multiple sexual partners, 57.5% also engaged in casual sex. For those who engaged in casual sex, **only 42% used a condom every time** they had casual sex. Further, of the 19.4% of female respondents reporting having multiple sexual partners, 19% also engaged in casual sex. Use of condoms among women in casual sexual relationships is generally low - **42% used a condom every time** they had casual sex.

Condom use among female sex workers with their last paying client is high (KAPB 2012, MTR 2013, GARPR 2014). In 2012, condom use among sex workers was 91% up from 85.2% in 2008. However, whilst sex workers tend to use condoms with their clients, condom use with regular clients is low. Sex workers contribute 10% of new HIV infections (MoT 2012). Condom use among MSM is above 70%. Data shows that 79% of MSM reported condom use the last time they had anal sex with a male partner. The reported condom use does not correlate to the high level of HIV among the population. MSM contribute to 30% of new infections based on the MoT Study 2012.

Early Sexual Debut: The median age of sexual debut in Jamaica is low. The KAPB Survey (2012) indicates that overall, 31.6% of persons aged 15 – 24 years old in Jamaica began having sex before age 15. The gender breakdown shows that 49% of young men and 12.5% of young women had sex before the age of 15. There is a high level of HIV prevalence especially among young girls aged 15–19 years and 20–24 years. This high level of HIV prevalence for younger women has been attributed to the fact that they are engaging in sex with older, more sexually experienced men and through coercion.

Another troubling trend is the matter of early sex and its impact among young gender and sexual minorities. Data indicates that the number of young MSM including bisexual boys aged 15 – 19 years old that is estimated to be in Jamaica is 6,250. Indications are that about 35% of YMSM has an STI. A similar issue is believed to be emerging among the country's estimated 1,310 transgender youth aged 15 – 19 years old. There still remains a paucity of information and research that focus on transgender persons in Jamaica.¹⁹

Transactional sex: Transactional sex (sex in return for gifts or favours) remains a troubling feature of the epidemic in Jamaica. Transactional sexual relationships, especially among youth aged 15 – 24 years old have increased. A total of 37% of persons reported being engaged in transactional sexual relationships in 2008 compared to 39% in 2012. Among youth, the figure moved from 39.1% in 2008 to 42.6% in 2012 (KAPB Survey 2012). Overall, 54% of males and 24% of females engage in transactional sex. However, only 50% used condoms to protect themselves all or most of the time. Of those who do not currently use a condom, 69% do not have any intention of changing their attitudes towards the use of condoms.

Other: Among the other major risk factors driving the HIV epidemic in Jamaica are the following **key underlying factors:**

- Stigma and discrimination: Deeply entrenched issues around stigma (both internal and external) and discrimination continue to pose a serious threat to the control of the HIV epidemic.
- Homophobia: Gender norms relating to sexuality and masculinity tend to privilege heterosexual relations. MSM may be reluctant to get tested due to stigma and discrimination, which is often caused by attitudes against homosexuality and/or bisexuality. Such attitudes reflect an emphasis

¹⁹ Jamaica National HIV/STI/TB Programme 25th Annual Review and Planning Retreat. 2015. Improving Quality of Care: The Case Management Approach – Meeting Report.



on heterosexual sex as a norm.²⁰ As a result, infected men may continue to have unprotected sexual relations and unknowingly transmit the infection to their partners (male or female).

- **Poverty:** Overall, unemployment in Jamaica is far higher among women in all age categories than males and there is a preponderance of women in the lower rungs of the labour market. For women and girls, poverty may increase vulnerability to HIV infection and force them to exchange unprotected sex for food, money, school fees or other basic needs.
- **Physiological, social, cultural and economic circumstances:** These have a disproportionately negative impact on the ability of key population and vulnerable groups to adopt protective behaviours and access HIV and SRH services;
- **Gender inequity:** Women, particularly adolescent girls, continue to be disproportionately affected by HIV in Jamaica. Many sexual and reproductive health problems are directly linked to gender inequity, including unintended pregnancies, STIs, gender-based violence and maternal mortality. Gender inequalities exacerbate women and girls' physiological vulnerability to HIV and block their access to HIV services
- **Gender norms and roles:**²¹ Gender norms and gender stereotypes affect HIV. Gender norms and cultural practices relating to sexual behaviour put men, women, boys and girls at risk and include the pressure to prove womanhood through early pregnancies and multiple partnerships.
- **Gender based violence:** Gender based violence (GBV)²² increases social vulnerability and is most often perpetrated by males against females. Cultural attitudes that disempower women and promote sexual violence as a reflection of masculinity limit safer sex negotiation for condom use and the refusal of sex, due to fear of violence (*Kempadoo, 2006*).

2.2 Jamaica's Progress

Jamaica has made significant progress in responding to the HIV epidemic through a coordinated response that has for decades received strong multi-sectoral support. In collaboration with key partners, the Government of Jamaica (GOJ) developed three 5-year National Strategic Plans to direct the implementation of the national HIV and AIDS response since 2005. Various Technical Working Groups (TWGs) covering mother to child transmission of HIV, key populations, prevention, treatment, monitoring and evaluation and enabling environment have been established to operationalise the Strategic Plans. Additionally, over the last decade or more, several sector-level plans and programmes have been put in place to guide HIV interventions.

Jamaica's response to the HIV and AIDS epidemic has matured significantly since 2005. Below are some of the key achievements.

Key Achievements

²⁰ Murray, G., M. Long & R. Nelson. 2017. Diversifying LGBT Rights Advocacy – A Legal Review. Kingston, Jamaica

²¹ Culturally, men have a large degree of control over women and prevailing values and norms uphold men's privileges and have tended to constrain women's autonomy. These values and norms are deep-rooted and facilitate the tacit acceptance of multiple and concurrent sexual partnerships (Simms, Glenda P. 2013. Gender Assessment of the National Response to HIV in Jamaica).

²² Violence that is directed at an individual based on his or her biological sex, gender identity or perceived adherence to socially defined norms of masculinity and femininity."(Kahn, 2011, cited in WHO)



The concept of one coordinating body realised

In 2013, the National HIV/STI Programme was integrated into the National Family Planning Board (NFPB) to create one executive agency with responsibility for sexual and reproductive health. The National Family Planning Board, empowered by the National Family Planning Act (1970), is the Government agency responsible for preparing, implementing, coordinating, and promoting sexual and reproductive health services in Jamaica.

National Integrated Strategic Plan for Sexual and Reproductive Health and HIV (2014 – 2019) Implemented

The plan serves as stakeholders' guide to the implementation of the national response to HIV/AIDS and Family Planning in Jamaica. The Plan outlines five priority areas: 1) Prevention and SRH Outreach; 2) Universal Access to Treatment, Care and Support and SRH Services; 3) Enabling Environment and Human Rights; 4) Monitoring and Evaluation of HIV, Family Planning and Sexual Health Response and 5) Sustainability, Governance and Leadership. Key targets include:

- Reduce by half, the number of new HIV infections by 2019
- Reduce the number of HIV related deaths by 25% by 2019
- Increase coverage of ARV treatment for PLHIV to 65% by 2019
- Increase to 90% the proportion of PLHIV on ART one year after initiating therapy

Increased strategic investments in the HIV response

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

Improved HIV Testing

Of the estimated 29,000 persons living with HIV infection in Jamaica, 81% have been diagnosed (aware of status). The magnitude of this achievement is such that up to 2010, epidemiological data indicated that only half (50%) of those infected with HIV were aware of their status. This represents a major success in the testing capacity of the country and an early indication that Jamaica is poised to meet at least the testing target of the UNAIDS 90-90-90 targets for 2020 aimed at ending the AIDS epidemic by 2030. HIV testing in settings such as STI Clinics as well as adult hospital admissions has reaped success as the majority of persons living with HIV diagnosed, were identified in these settings. There has also been an increase in the coverage of community based HIV interventions particularly to key populations in both urban and rural areas and also in communities that are not easily accessible.

Reduced HIV Infections

Jamaica is among four countries in the Caribbean region that has recorded declines in new HIV infections between 2005 and 2015. The number of newly reported HIV cases has declined by 25% in the last 10 years. HIV prevalence for 2015 stands at 1.6% down from 1.7% in 2012.

Infection rates among sex workers have also shown significant reductions falling from 9% in 2004 to 2.9% in 2015²³.

HIV prevalence among STI clinic attendees declined from 7% in 1999 to 2.84% in 2015.

Improved access to treatment and care for PLHIV

Since 2004, there has been a consistent increase in the number of people on antiretroviral therapy and a 76% reduction in AIDS-related mortality.

A key achievement in treatment and care was the introduction of the Care Continuum in 2013. In response to the high levels of loss to follow up among PLHIV on HAART, the National Programme adopted the Continuum of Care approach and started to track the country's efforts in improving the care continuum for persons living with

²³ Ministry of Health/National HIV/STI Unit. 2015. HIV Epidemiological Profile 2015, Facts & Figures



Improved Data Collection on HIV	<p>HIV. The approach was introduced to ensure that all persons with HIV are diagnosed, linked to treatment and care and achieve viral load suppression. Viral load suppression is a marker of a person's strong immune system and overall health. At the end of 2016, 43% of those diagnosed as HIV positive were on treatment and 55% of those on treatment were virally suppressed. Access to viral load testing also improved markedly in 2016, with 90% of PLHIV on ART having a viral load result documented in their health record.</p> <p>The National HIV/STI/TB Unit introduced, DHISII, a new web-based data collection platform that links the databases across all treatment sites. Prior to the introduction of the database, it was difficult to, among other things, track and manage patients who sought care at multiple sites and collate data for national analysis and reporting. Additionally, the unit implemented the Unique Identifier Code (UIC) for PLHIVs. Together, the implementation of both systems will enable both the HIV treatment sites and prevention services to be able to access a comprehensive history of services received by clients.</p>
Mother to child transmission of HIV at elimination level	<p>Data indicates that Jamaica has been able to sustain a below 2% (elimination level) HIV transmission from mother-to-child since 2011²⁴. The MTCT has continued to decline and in 2016, only 1% of babies were infected with HIV.</p> <p>A multi-sectoral steering committee was established in 2012 to provide technical guidance to ensure the EMTCT programme meets all structural and data requirements for achieving elimination status by 2015.</p>
Expanded HIV and AIDS Programming for youth	<p>The Adolescent and Youth Component of the National HIV/STI/Tb Unit was introduced as new component to the response. As a result starting in 2015, programmes for adolescents increased with the introduction of the All In initiative, a partnership between the Ministry of Health and UNICEF. The All In initiative targets adolescents aged 10 to 19 years and is part of the global push to end the AIDS epidemic for all by 2030. The mandate of the Adolescent and Youth component is guided by the All In Youth and Adolescent Technical Working Group (YATWG) and the Adolescent Policy Working Group (APWG).</p>
Social and economic impacts of HIV addressed	<p>Development of Adolescent Reproductive Health Standards and Criteria: These standards were developed to assure quality reproductive health services for adolescents and to reflect the broader goal of adolescent health. Ten (10) Standards and 37 Criteria were developed. The manual was disseminated to health care workers and other partners. Training was also conducted on the Standards and Criteria.</p> <p>In recognition of the socio-economic impacts of HIV, the National HIV/STI/Tb Unit provides each Regional Health Authority (RHA) with a cadre of Adherence Counsellors, Psychologists and social workers to interface with positive clients. These individuals work closely with the Physicians, Nurses, laboratory staff, nutritionists, and pharmacists to provide holistic care to the clients. PLHIV have also been able to access income generating grants to provide basic income and to support themselves and their children.</p>
Improving enabling environment through legislative and policy reform	<p>Since 2005, several regulations, policies and plans relevant to HIV and AIDS have been implemented. Among the main policies are the National Workplace Policy on HIV/AIDS and the Management of HIV/AIDS in Schools Policy. A comprehensive list of relevant policies, strategic plans and regulations is summarised in Annex 2.</p> <p>To address the SRH situation of adolescents in Jamaica, a draft Cabinet Submission was submitted in 2014 on the 'Access to medical information, advice, health and health-related services by sexually active persons below the age of majority (18 years) at public health facilities'. The document requested Cabinet to consider amendments</p>

²⁴ Ibid



to the Law Reform (Age of Majority) Act (1979) and the Sexual Offences Act (2009), to allow “medical professionals, teachers, guidance counsellors and social workers to provide age-appropriate medical and non-medical information, advice and services (including contraceptives) to sexually active persons who are 12 years and older, but who have not yet attained the age of majority (18 years), without the need for parental consent, provided certain conditions are satisfied.”

Strong linkages and partnerships

Additionally various research data has been produced by external agencies and civil society organisations geared at improving the legislative and policy environment.

The Government, international development partners, PEPFAR, USAID and the Global Fund to fight AIDS, Tuberculosis and Malaria (GFTAM) continue to provide funding for the national response. Stakeholder involvement and participation in the response by non-governmental organisations (NGOs), people living with HIV and AIDS (PLWHA), civil society groups, faith-based organisations and the private sector have also increased. This has allowed for cohesion and consensus on some of the critical issues and actions to be taken in the national response.

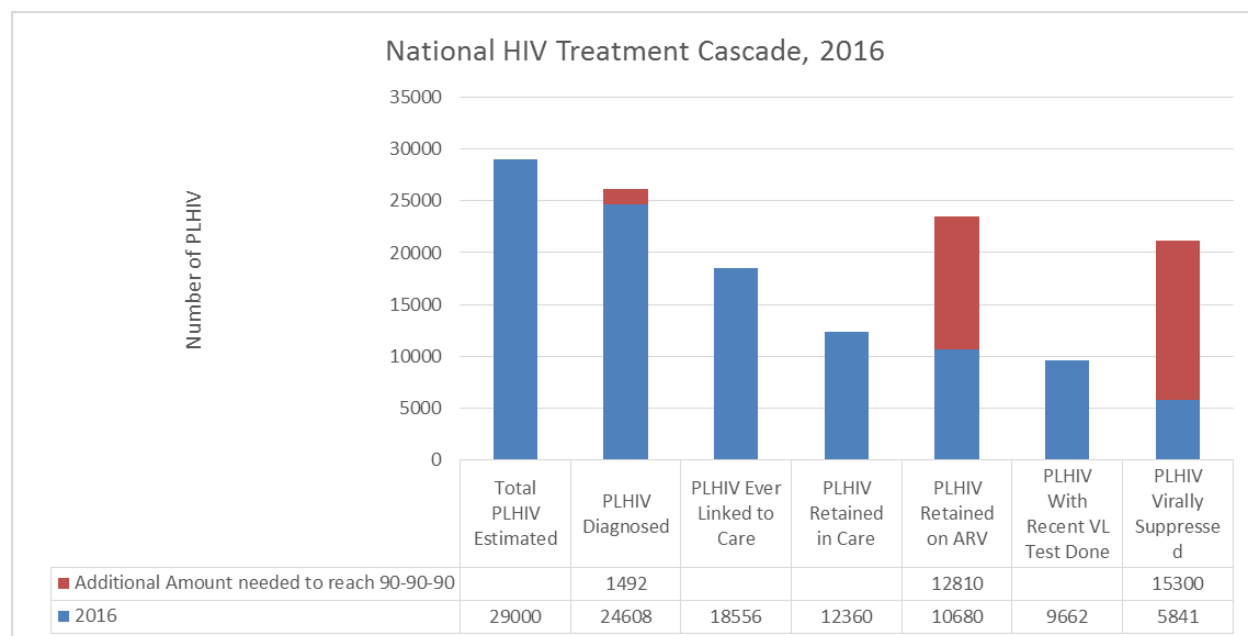
2.3 Challenges

The national HIV response is plagued by numerous challenges which act as barriers to the implementation of programmes and interventions. Notwithstanding the positive developments highlighted, HIV prevalence remains at an alarming rate among some key population groups. In addition, there are some systemic issues such as inadequate health and physical infrastructure; weak leadership and governance at the intra-regional levels and inadequate human resources.

HIV treatment is a major challenge. Currently in relation to the 90-90-90 treatment target to end AIDS, Jamaica by the numbers is 81-43-55. That means that in Jamaica, 81% of the adults living with HIV currently know their status, 43% of people living with HIV who know their status are receiving antiretroviral therapy, and 55% of them have achieved viral suppression. Significant steps will need to be taken if Jamaica is to achieve the targets set by 2020.



Figure 1: Jamaica’s Treatment Cascade 2016



Source: Draft National HIV/STI/TB Unit Annual Report 2016

As Figure 1 above shows there is a serious gap in HIV treatment. An estimated 75% of persons who are diagnosed with HIV are linked to care; of those who are linked to care, 67% have been retained in care. Adherence to treatment is a challenge and drop-out and loss to follow up are major challenges in the health service delivery system – 55% of persons on ART are not virally suppressed. The cascade demonstrates that a number of underlying challenges need to be addressed. At the level of the healthcare delivery system this relates to insufficiency in the areas of:

- Referral systems
- Systems to follow up on persons who were tested positive, on those who drop-out, and adherence support systems,
- People centeredness approaches that lower barriers to utilization of services and that are friendly towards key populations and free from stigma and discrimination
- The interface between health services and civil society organizations that reach out to key populations.

Barriers to care such as stigma and discrimination, staff shortages, inadequate linkages with civil society and private sector organizations also further widen the gaps that exist in the continuum of care.

When examined separately, the cascade of treatment for key populations shows that while a greater number of homosexuals are linked to care when compared to bisexual men and female sex workers, the rates of retention in care are highest for bisexual men (88%). The prevalence of PLHIV on ART, the prevalence of viral load testing and the viral suppression is lowest (28%) amongst female sex workers (whose prevalence of HIV infection is 2%) and highest amongst the homosexual population (38%)²⁵.

²⁵ National HIV/STI/TB Unit. 2017. Draft National HIV/STI/TB Unit Annual Report 2016



With respect to the youth and adolescent populations living with HIV, approximately three times as many persons between the ages of 20 and 24 years are linked to care when compared with those who are 15 to 19 years old. At least twice as any persons aged 10 to 14 years are linked to care when compared with those 15 to 19 years of age. For those aged 10 to 14 years however, the prevalence with which they are retained in care (8%) is considerably lower than those 15 to 19 years old (44%). The trend continues along the continuum of care for those 10 years to 14 years, where the cascade shows that prevalence of viral load testing (6%) and viral suppression (3%) lag behind the other age groups.

Other identified key challenges and risk factors are highlighted below.

Structural Issues

Stigma and Discrimination

Stigma and discrimination associated with HIV and AIDS continues to be problematic especially in the health sector. The KAPB (2012) indicates that 33.83% (33.8% males/33.85% females) of persons 15-49 years of age expressed accepting attitudes towards people with HIV/AIDS (in 3 components: school teacher, look after family member, not keep it a secret). Similarly accepting attitudes towards persons engaged in same sex relationships tends to be low.

Generally, the KAPB (2012) indicates that accepting attitudes towards persons engaged in same sex relationships tends to be low. Data reveal that 30.6% of Jamaicans reported they would still buy food/vegetables from a shopkeeper or food seller if they knew he was gay; 57.7% reported they would feel uncomfortable if they found out their neighbour was gay; 60.3% said if they found out a member of their household was gay, they would want them to leave the house and 77.9% stated that when a person is gay they bring shame on the family.

Poverty

It is globally recognised that HIV increases poverty and poverty is a determinant of HIV. Whilst there are no empirical data in Jamaica on the co-relation between poverty and HIV, anecdotal evidence point to lack of funds for transport and meals as deterrents to adherence. There is limited psychosocial support and counselling services to address social vulnerabilities such as poverty and lack of food. Additionally, whilst ARVs are free of cost, support for the treatment of opportunistic infections, STIs, and psychosocial structures is limited.

Household surveys in Jamaica point to the fact that poverty affects women more than men. With fewer economic resources, young women more often than men will engage in transactional and cross generational sex with older men to gain materially, affirm their self-worth, achieve social goals, and increase longer term life chances. This diminishes their capacity to negotiate safer sex and to leave abusive relationships (CEDAW Report, 2012).

Gender Inequality

Gender equality is enshrined as a principle in Vision 2030 Jamaica, the National Integrated Strategic Plan 2014 – 2019 and the National Policy for Gender Equality. Although there is no national strategy pertaining specifically to women and HIV women, it is globally accepted that women are often adversely affected by the HIV and AIDS epidemic than men due to biological, socio-cultural and economic reasons. Women and girls are not recognized as a key population in the context of HIV and there is no legislative or policy framework to ensure access to comprehensive sex, health, and HIV education, and prevention, care, and support services including their full sexual and reproductive health and rights. Additionally, the sexual diversity of women, including



lesbians, bisexual and transgender women, are not addressed at the policy level in terms of access to health care.²⁶

Limited access to social protection

The National HIV/AIDS Workplace Policy 2012 Objective 4 addresses the importance of mitigating the socio-economic impact of HIV and AIDS on individuals and families through a number of measures. However, a study funded by the United Nations Development Programme in 2013 entitled “Assessing a Social Protection Framework for Vulnerable People Living with HIV in Jamaica” indicated that there are no specific provisions or actions to guide social protection initiatives that have high relevance to PLHIV and households affected by HIV within PATH, the School Feeding Programme or Poor Relief.

Additionally, the study found that there are no laws to safeguard the right of PLHIV to an adequate standard of living and social protection in the event of unemployment, sickness, or disability, and to protect PLHIV and their households from stigmatizing, discriminatory and violent actions.

Behavioural Factors/Risk Behaviours

Knowledge of HIV among youth

Knowledge about HIV Prevention among youth aged 15 – 24 years old moved from 40.2% in 2008 to 38.5% in 2012. The performance for this indicator (38.5%) is of concern as the country missed the 2010 Millennium Development Goal (MDG) target of 95% by 2010 and the national target of 60% by 2011. The national target goal post has moved to a 2017 marker of 60% to be met.

Multiple Sexual Partnerships

Jamaica continues to struggle to address this behaviour with more than 80% of PLHIV reporting multiple sexual partnerships as a risk factor (MOH, 2011). Cultural norms, in addition to the effects of the global economic crisis which has worsened poverty, limited resources and homelessness have been attributed to the increasing number of persons reporting multiple sexual partnerships. Sixty-three per cent of Jamaicans engaged in multiple sexual partnerships reported they used a condom the last time they had sex (KAPB, 2012).

Transactional Sex/Cross-generational sex

Transactional sexual relationships, especially among youth aged 15 – 24 years old are a troubling trend. A total of 42% of persons reported involvement in 2012. Overall, 54% of males and 24% of females engage in transactional sex. A C-Change study on Cross-Generational Sex in Jamaica highlighted that the three main drivers were: sexual gratification, emotional support/security, and financial gain. The primary motivator for males was sexual gratification and for females, emotional support. The study notes the need to address the first two drivers rather than the singular focus on the latter. It also must address the extreme power inequities that exist within these types of relationships for younger participants.²⁷

HIV prevalence among Key Populations

Although HIV prevalence has remained at below 2% among the general population, prevalence among key population groups remain high with MSM population proving to be the most troubling at 32.8%.

Institutional, legislative and policy Issues

²⁶ UNDP, Jamaica. 2013. Legal Reforms, Social Change: HIV/AIDS, Human Rights and National Development in Jamaica.

²⁷ Tureski K., K. O'Connor Anderson, S. Rogers, and A. Cushnie. 2012. Cross-Generational Relationships: Perceived Norms and Practices in Jamaica. Washington, DC: C-Change/ FHI 360.



Criminalisation of sexual behaviours and practices

Private, consensual same-sex sex acts are criminalized in the Offences against the Person Act. The Offences Against the Persons Act sections 76, 77 and 79 criminalize same-sex male intercourse. The Act of criminalising same sex-male intercourse further fuels stigma, discrimination and other human rights violations towards MSM.

UNDP (2013) indicates that the criminalization of same-sex acts, sex work, and drug use makes it difficult for civil society organisations to provide HIV/AIDS-related information openly. Further, the assessment notes 'there is no law or policy to ensure that PLHIV, HIV and AIDS advocates, and service workers enjoy the rights to freedom of opinion and expression. There are also no legal sanctions against HIV- or key-population-related hate speech.'²⁸

Access to SRH and HIV services by minors

The Offences Against the Person and the Sexual Offences Acts operate as barriers to health care professionals who want to provide sexual and reproductive health information to children under 16 years. Some healthcare professionals are reluctant to provide the necessary information due to fear of prosecution for "aiding and abetting" a criminal act - sex with a minor, which is prohibited in the Sexual Offences Act.

UNAIDS (2013) posited that the current legislative framework does not support the scaling up of the national response to the level required to reduce HIV incidence and control prevalence. The assessment noted *inter alia* the need to address voluntary counselling and testing (VCT) and access to SRH services for minors; address the dissonance between the existing legislative framework and policy guidelines for example the Law Reform (Age of Majority) Act, Child Care and Protection Act and the Contraceptive Guidelines for Minors.

Outside of the challenges indicated above, there are identified key population and vulnerable groups that the current HIV response does not adequately address. These include:

- a. **Orphans and children made vulnerable by HIV:** With repeat pregnancies among HIV positive mothers at 40% and the success of the pMTCT programme, it would appear there is need to address this gap. Christie et al (2012) noted that public access to antiretroviral therapy (ART) has shown that the test and treat strategy linked to treatment as prevention has worked very well for HIV-infected pregnant women by reducing MTCT of HIV. The authors note that although they have been very successful at preventing infection of the children, the mothers tend to experience significant psychosocial stress and there is need for targeted interventions to assist them to improve their quality of life. The research also indicated that HIV-infected Jamaican children are surviving into adolescence and adulthood, and as a result require programmes that will include addressing sexual and reproductive health issues, psychosocial, educational and vocational issues as well as palliative care.
- b. **Persons with disabilities (PWDs).** Persons with disabilities have for years been left out of HIV and related initiatives in Jamaica by both the National Programme and civil society. Ad hoc interventions have taken place between 2006 and 2014, but to date there has been no sustained interventions. UNAIDS (2014) indicated that persons with disabilities have an unmet need for health and HIV services and represent one of the largest and most underserved populations globally. The main reasons posited for this state are: Lack of awareness by national HIV response programmes, sexual violence, low awareness and risk perception about HIV and discrimination in health care settings.

²⁸ UNDP, Jamaica. 2013. Legal Reforms, Social Change: HIV/AIDS, Human Rights and National Development in Jamaica.



- c. **HIV and the aging population.** Jamaica's population over 50 years old stands at 584,835 persons (STATIN 2013). Based on 2012 data, 18% of the cumulative HIV cases are between 50 and 94 years old. The 2014 WHO Global Update on the Health Sector Response to HIV highlights that there is a growing number of people aged 50 and over living with HIV. It indicated that the need for HIV prevention and other services to respond to older people's needs.
- d. **Transgender persons.** Globally, evidence suggests that transgender women are disproportionately affected by HIV with one study in the United States putting the risk at 34.2 times higher for transwomen than the United States adult population.²⁹ In Jamaica, little has been explored with regard to sexual and reproductive health needs among transwomen. Available evidence from the 2010 MSM survey highlighted a segment of the population that identified as being of feminine gender, having an elevated risk of HIV with a prevalence of 39%. Transgender women that identified as sex workers had an even greater prevalence of 48%. Interventions that reach this population are not specific to TG needs and are usually delivered through MSM programmes although transwomen do not necessarily identify as men. In 2016, the National Family Planning Board reached 301 persons in this key population and was successful in testing approximately 23% of them (69 persons)³⁰. Transgender persons, based on information from the NFPB are hardest to self-identify, reach and test. This is an area of concern that needs to be explored further so as to establish commonalities within a strategy to identify, reach and test transgender persons.
- e. **Lesbian, Gay, Bisexual, and Transgender Youth Who Are Homeless:** A disproportionate number of lesbian, gay, bisexual and transgender (LGBT) youth experience homelessness in Jamaica. LGBT youth who are homeless have particularly high rates of mental health and substance use problems, suicidal acts and engage in a range of HIV risk behaviours. Given the intense needs of LGBT youth experiencing homelessness, it is imperative that the country develops responsive programmes and policies.

²⁹Reback CJ, Fletcher JB. 2014. HIV prevalence, substance use, and sexual risk behaviours among transgender women recruited through outreach. Published in AIDS Behaviour. 2014 Jul. 18(7):1359-67. doi: 10.1007/s10461-013-0657-z

³⁰ National HIV/STI/TB Unit. 2017. Draft National HIV/STI/TB Unit Annual Report 2016.



3 POLICY FRAMEWORK

3.1 Guiding Principles

This Policy is guided and underpinned by Vision 2030 Jamaica -National Development Plan; the National Integrated Strategic Plan on HIV and SRH 2014 – 2019 and the National Work Place Plan on HIV which precede it.

The Policy also takes into account international conventions, treaties and protocols signed and ratified by Jamaica. These include:

- The International Conference on Population and Development Programme of Action adopted at the United Nations (UN) in Cairo, September 1994.
- Beijing Declaration and Platform for Action of 1995
- The Millennium Development Goals (September 2000)
- The United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/AIDS, June 2001 and June 2011.
- The ILO Code of Practice on HIV/AIDS and the World of Work 2001 and 2006.
- The Sustainable Development Goals (2015)

The overarching principles of protection, confidentiality, consent and data protection are enshrined in this policy and applicable throughout. This policy encourages results-oriented programmes and interventions.

This policy is guided by the following specific principles:

1. *Political Leadership and Commitment:* Strong political leadership and commitment at all levels is essential to a sustained and effective response to HIV and AIDS.
2. *Good Governance, Transparency and Accountability:* An effective national response to the epidemic requires leadership to mobilize and manage human, financial and organizational resources in an effective, transparent and accountable manner. The policy should be publicly available and progress reviewed against benchmarks every two years.
3. *Promotion and Protection of Human Rights*³¹: The protection and promotion of human rights are essential to ending the AIDS epidemic in Jamaica. Therefore, a rights-based response will demand that government promotes a supportive and open environment for those infected with HIV or those most vulnerable to HIV infection.³² It is important that the rights to equality before the law and freedom from discrimination are respected, protected, promoted and fulfilled. The protection, non-discrimination, non-stigmatisation of PLHIV, key populations and all other vulnerable groups will be

³¹ The Office of the High Commission for Human Rights defined HIV-related human rights as: 'the right to life; the right to liberty and security of the person; the right to the highest attainable standard of mental and physical health; the right to non-discrimination, equal protection and equality before the law; the right to freedom of movement; the right to seek and enjoy asylum; the right to privacy; the right to freedom of expression and opinion and the right to freely receive and impart information; the right to freedom of association; the right to marry and found a family; the right to work; the right to equal access to education; the right to an adequate standard of living; the right to social security, assistance and welfare; the right to share in scientific advancement and its benefits; the right to participate in public and cultural life; and the right to be free from torture and other cruel, inhuman or degrading treatment or punishment.' Accessed at <http://www.ohchr.org/EN/Issues/HIV/Pages/HIVIndex.aspx> on May 15, 2015.

³² Joint United Nations Programme on HIV/AIDS (UNAIDS) 2006. International Guidelines on HIV/AIDS and Human Rights 2006 Consolidated Version. Switzerland. Accessed at <http://www.ohchr.org/Documents/Publications/HIVAIDSGuidelinesen.pdf> on May 15, 2015.



applied across all HIV programme areas. Discriminatory practices (including unequal gender relations) create and sustain conditions leading to vulnerability to HIV infection and to inadequate treatment, care and support as well as access to prevention services.

4. *Greater Involvement of People Living with HIV:* It is essential that PLHIV are fully engaged in designing, implementing, and evaluating policies, programmes, and research that impact them.
5. *Multi-sectoral Approach and Partnerships:* The active involvement of all sectors of society, including faith based organisations (FBOs) and the private sector, is necessary to ensure an effective response, including effective partnerships, consultations and coordination with all stakeholders in the design, implementation, monitoring and evaluation of the national response to HIV and AIDS.
6. *Key Stakeholder Participation:* The meaningful participation of people living with and affected by HIV and AIDS, key populations and vulnerable groups in the design, implementation, monitoring and evaluation of the national response to HIV and AIDS is vital to optimise stated outcomes. Emphasis on youth/adolescents living with HIV, including those infected prenatally, should also be sought.
7. *Universal Access and Inclusion:* Responses to HIV and AIDS should ensure that no person is denied access to prevention information, knowledge, skills and services or treatment, care and support services on the basis of their real or perceived HIV status, sexual orientation, gender, age, disability, religious or other beliefs, socio-economic status, geographic location, level of literacy, capacity to understand the nature of HIV and how it is prevented and treated or vulnerability to exposure. This includes orphans, wards of the state, men who have sex with men, sex workers, street and working children, persons living with disabilities, prisoners, drug users and homeless persons..
8. *Gender Responsive Programming:* Gender equality and equity is to be applied in all programming and prevention interventions to meet the unique needs of women, girls, men and boys.
9. *“Three Ones” Principle:* Interventions will be implemented within the ‘Three Ones’ principle – One HIV and AIDS Action Framework, One National AIDS Coordinating Authority and One Monitoring and Evaluation System.
10. *Integration of Services:* HIV services should be fully integrated within the broad range of sexual and reproductive health services. In addition, the integration of HIV services with chronic non-communicable diseases (CNCDS) should be started. This becomes more and more important as PLHIV live longer and develop co-morbidities.
11. *Evidence-Based Programming:* Interventions are to be designed based on the specific conditions of vulnerability and risk behaviours verified to be driving the epidemic within locations and populations of focus. HIV programmes should also be designed based on the relevant epidemiological, economic, social and age contexts. There is to be systematic review, reform and strengthening of policies for effective evidence-based HIV programming.
12. *Comprehensiveness of services and Continuity in care:* HIV services should be comprehensive, including health promotion and combined preventive interventions, care, support and treatment services that address the population’s needs for HIV prevention as well as the broad set of services for PLHIV. The continuity of care should be guaranteed across the different service providers, different levels of care and throughout the life cycle of people.
13. *Address structural determinants:* The root causes of HIV need to be addressed. This includes action to reduce poverty, ensure equity of access to key health services and improve access to information and education opportunities

3.2 Vision Statement

All Jamaicans have access to comprehensive, rights-based HIV and Sexual and Reproductive Health (SRH) Services.



3.3 Policy Goal

Jamaicans enjoy equitable and rights-based access to high-quality, high impact and sustainable integrated sexual and reproductive health and HIV services.

3.4 Policy Objectives

1. Promote and provide universal access to prevention interventions for all
2. Scale up the provision of and delivery of prevention commodities, SRH information and services, BCC interventions and related services.
3. Ensure universal access to treatment, care and support services for all without discrimination or barriers
4. Promote respect for human rights in dealing with HIV and AIDS issues at policy and programme levels
5. Alleviate the socioeconomic effects of HIV and AIDS at individual, household and community levels
6. Integrate and align policies, strategies and resources for HIV within a responsive health system and other sectors

3.5 Policy Outcomes

The policy seeks to set standard guidelines for programmatic, institutional and social responses in priority and other strategic intervention areas for HIV and sexual and reproductive health services. The expected results to be achieved are:

1. Reduced new HIV infections – **Target:** 90% reduction in new adult HIV infections, including among key populations by 2030.
2. HIV-associated deaths reduced through the provision of ARVs, ART, nutrition, psycho-social and other support – **Target:** 90% reduction in AIDS-related deaths by 2030.
3. MTCT of HIV eliminated by 2020 – **Target:** zero new infections among children
4. The human rights of everyone (including SRHR) are respected, protected and upheld. **Target:** 90% reduction in stigma and discrimination faced by people living with HIV and key populations by 2030.
5. An enabling environment created that promotes health and wellness to alleviate the social, psychological and economic impacts of HIV and AIDS at individual, household and community levels.
6. The integration of SRH and HIV and the alignment of policies, strategies and resources for HIV within a responsive health system and other sectors ensured

3.6 Legal and Policy Context

3.6.1 THE JAMAICA CONSTITUTION

The Jamaican Constitution addresses discrimination generally and guarantees equal treatment under the law regardless of race, political opinion, place of origin, colour, creed or sex. The Constitution also grants all citizens the right to life; the right to personal liberty; security of person; freedom of movement; freedom from inhuman treatment or punishment; enjoyment of property; freedom of conscience and expression; freedom of peaceful association and assembly; respect for private and family life; freedom



from discrimination on the grounds of race and the right to vote. The Jamaican Constitution does not have a provision on the right to health.

3.6.2 THE CHARTER OF FUNDAMENTAL RIGHTS AND FREEDOMS (CONSTITUTIONAL AMENDMENT) ACT, 2011.

The Act seeks to “provide more comprehensive and effective protection for the fundamental rights and freedoms of all persons in Jamaica”. Section 13(i) of the Charter of Fundamental Rights and Freedoms prohibits discrimination on the grounds of i) being male or female; ii) race, place of origin, social class, colour, religion or political opinions. It does not prohibit discrimination on the grounds of health status, HIV status, gender identity, sexual orientation, or disability.

3.6.3 VISION 2030 JAMAICA – NATIONAL DEVELOPMENT PLAN

Vision 2030 Jamaica is Jamaica’s first long-term National Development Plan which aims to put Jamaica in a position to achieve developed country status by 2030. It is based on the vision: “Jamaica, the place of choice to live, work, raise families, and do business”. The Government of Jamaica considers HIV and AIDS a national development threat and therefore, it is incorporated in the Health Sector Plan.

3.6.4 SUSTAINABLE DEVELOPMENT GOALS

These are a set of goals, targets and indicators that UN member states will be expected to use to frame their agendas and political policies over a 15 year period. Of the 17 proposed goals and 169 proposed targets within the Outcome Document, SRH and HIV and AIDS are specifically referenced in the following goals: Goal 3: ‘Ensure healthy lives and promote well-being for all at all ages’ and Goal 5: ‘Achieve gender equality and empower all women and girls’.

3.6.5 90-90-90 TREATMENT TARGET TO END AIDS³³

The target refers to three key steps that UNAIDS deem essential to both better health and care for HIV positive people and to limiting new infections and the further spread of the HIV epidemic. The targets are: (1) By 2020, 90% of all people living with HIV should know their status, (2) By 2020, 90% of all those who are diagnosed with HIV to be on sustained antiretroviral treatment (ART) and (3) By 2020, 90% of those on ART having an undetectable viral load.

1.5. Scope of Application

The policy applies to Government and all other stakeholders and partners involved in and supporting the country in the national response to the HIV epidemic. It requires all Ministries, Departments and Agencies (MDAs), stakeholders and other partners to mainstream HIV and AIDS into their plans and programmes. The measures outlined in this policy are to be used to guide the development of National Strategic Plans and Action Plans, sectoral and thematic HIV and AIDS policies, operational guidelines, and programmes, including service delivery at all levels.

³³ Joint United Nations Programme on HIV/AIDS. 2014. 90-90-90 An ambitious treatment target to help end the AIDS epidemic. Accessed at http://www.unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf on October 6, 2017.



2. PREVENTION OF NEW HIV INFECTIONS

2.5. Introduction and Rationale

Ministry of Health records show that over the last three years, the number of newly diagnosed and reported HIV cases declined by 21.2%. Currently, an estimated 29,000 persons are living with HIV. Whilst the national HIV prevalence stands at 1.6%, the rate among some key populations currently exceeds the national rate with the highest of 32% among MSM. Other data point to a rate of 2.9% among female sex workers (SW) and homeless drug users of 4%.

A worrying trend concerns transgender women. Available evidence from the 2011 MSM survey highlighted a segment of the population that identified as being of feminine gender (21%), having an elevated risk of HIV with a prevalence of 39.7%. Transgender women that identified as sex workers had an even greater prevalence of 55.6%.

Additionally, although the epidemic affects more men than women, over time females are accounting for an increased proportion of the AIDS cases that are reported annually. Between 2007- 2012, there was a 40% increase in the number of reported cases among women, moving from 339 (2007) to 563 (2012). Young females aged 10 – 29 years old typically account for the larger share of the reported cases. Today, the proportion of newly diagnosed males and females are roughly equal with males (609) accounting for slightly less (49.8%) newly diagnosed cases than females (613; 50.2%).

Lessons learnt indicate that preventing new infections lie at the heart of the elimination of the transmission of the HIV. To address the multiplicity of factors that fuel the spread of HIV infection in Jamaica, a comprehensive prevention approach must be adopted. The policy measures will therefore provide a framework to enable the reduction of the risk profile of the population through the implementation of five priority strategies— increased comprehensive knowledge about HIV, reduction of multiple sexual partnerships, increased use of treatment as prevention and increased targeted interventions for PLHIV, key populations and other vulnerable groups and increased consistent and correct condom use.

2.6. Objectives

1. Promote and provide universal access to prevention interventions for all
2. Scale up the provision and delivery of prevention commodities, SRH information and services, BCC interventions and related services.
 - a.

2.7. Main Policy Statements

1. Universal access to SRH and HIV information and services for all regardless of age, sexual orientation, social and economic status and political affiliation.
2. All Jamaicans must have access to comprehensive, age appropriate, context specific, information on SRH and HIV.
3. Affirm human rights of key populations and ensure comprehensive access to prevention information and services
4. Ensure consistent supply of quality HIV prevention commodities



2.7.1. COMPREHENSIVE KNOWLEDGE ABOUT SRH AND HIV

The Knowledge Attitude and Behaviour Survey (2012) indicated a decline in percentage of persons aged 15 – 24 years old being able to correctly identify ways of preventing HIV and rejecting major misconceptions about HIV transmission from 40.2% in 2008 to 38.5% in 2012. The performance for this indicator (38.5%) is of concern. The national target goal post has moved to a 2017 marker of 60% to be met.

The lack of comprehensive knowledge affects risk perception which in turn results in risky sexual behaviours and increased HIV transmission. Interventions aimed at increasing comprehensive knowledge and overcoming the myths associated with HIV should be expanded and enhanced. To address this:

- a. A national HIV prevention minimum package on comprehensive knowledge about HIV that includes information on available HIV prevention services must be developed and include information on the risk factors and key drivers.
- b. All Jamaicans must have access to evidence-based age and sex appropriate HIV prevention information and education.
- c. HIV prevention interventions must be integrated into all Sexual and Reproductive Health (SRH) services.
- d. SRH education must be fully integrated into education programmes offered to children aged 10 – 18 at the primary and secondary level.
- e. Safer Sex practices including abstinence should be promoted among youth in secondary schools
- f. Parents of primary and secondary school children should be included in SRH education at the planning and implementation stages to help to reduce pregnancy and STIs among young person
- g. HIV prevention information, sexual and life skills education must be available, accessible and tailored to the needs of both in-school and out-of-school youth.
- h. All SRH services and commodities should be made accessible to all individuals regardless of gender, gender identity, sexual orientation, ability, economic and social status and in accordance with national protocols and guidelines.
- i. HIV prevention interventions should strongly promote dual protection against STIs, HIV and unintended pregnancy.
- j. The SRH needs of PLHIV should be recognised and adhered to in compliance with the UN Office of the High Commission for Human Rights.
- k. Abstinence and mutual faithfulness among adult sexual partners must be promoted as part of comprehensive sexual and reproductive education.
- l. Comprehensive sexual and reproductive education should be expanded to include raising awareness on sexual violence and must aim to increase reporting of sexual violence

2.7.2. MULTIPLE SEXUAL PARTNERSHIPS (MSP)

Multiple sexual partners is the most immediate cause of new HIV infections and significantly correlates with the majority of drivers of the epidemic (MoT 2012, KAPB 2012).

The Mode of Transmission Study 2012 indicated that the increase in the number of reported HIV and AIDS cases among women may be indicative of exposure through MSM or other high risk male partners, and not evidence that the epidemic is spreading independently in the general population (MOT, 2012, GARPR 2014). Other literature however point to issues of gender inequality and sexual violence. Cultural norms and values shape negative gender relations that help drive the epidemic. Culturally, men have a large degree of control over women and prevailing values and norms uphold men’s privileges and have tended to constrain women’s autonomy. These values and norms are deep-rooted and facilitate the tacit



acceptance of multiple and concurrent sexual partnerships.³⁴ The following statements support addressing the issue of MSP:

- a. Partner reduction should be the key prevention message across all sectors. This should be aimed at increasing risk perception amongst different population groups and locations.
- b. All interventions for partner reduction should integrate male and female condom use into their messaging to ensure that populations are utilizing commodities aimed to protect them from sexually transmitted infections.
- c. Young people and pre-adolescent aged children should be specially targeted with age-appropriate messaging aimed at influencing behaviour formation.
- d. Risk perception messages on how age-disparate relationships promote new HIV infections should be a key approach to reducing MSP especially among young girls and young MSM.

2.7.3. ART AS PREVENTION

This policy recognises the prevention benefits of effective treatment. ARVs work to reduce the amount of the virus (viral load) in the positive person's body, thus reducing progression to AIDS-related illnesses. The viral load is the single biggest risk factor in the transmission of HIV. To accelerate AIDS treatment globally, the WHO in 2015 recommended that anyone infected with HIV should begin antiretroviral treatment as soon after diagnosis as possible. In making this recommendation, the WHO effectively removed all limitations on eligibility for antiretroviral therapy (ART) for people living with HIV. It meant that all populations and age groups were now eligible for treatment.

The WHO recommendation is backed by findings from clinical trials which confirmed that early use of ART keeps people living with HIV alive, healthier and reduces the risk of transmitting the virus to their partners. Jamaica officially accepted the WHO recommendation in 2016 and began roll out of the policy in 2017.

The following policy guidelines should be adopted:

- a. ART is to be offered to all PLHIV once diagnosed and assessed to be treatment ready as per the Clinical Management of HIV Disease - Guidelines for Medical Practitioners 2017.
- b. ART when applied, must be complemented by SRH and HIV education, counselling and guidance based on individual situation, condom use and behaviour change interventions
- c. The Test and treat approach should take into consideration the rights of the individual. This is because ARVs can cause serious side effects and can lead to drug resistance if not taken exactly as prescribed. Therefore an HIV-positive person has the right to decide whether or not to take the treatment by weighing the pros and cons.

2.7.4. CONDOM USE

UNAIDS (2016) noted that 'condom programming needs to be predicated on sexual and reproductive health and rights and gender equality.'³⁵ Correct and consistent condom use is a proven measure of protection against HIV. However, whilst knowledge of the value of condoms for HIV prevention is high among all populations, practice is variable and generally low. As such:

- a. Condoms must be affordable and accessible to everyone, including key populations
- b. Condoms should be available in the public and private sectors at free or low cost and without restrictions on age or sexual behaviour.
- c. Condom programming must be strengthened to:
 - i. focus on further expansion to non-traditional condom outlets;

³⁴ Simms, Glenda P. 2013. Gender Assessment of the National Response to HIV in Jamaica

³⁵ UNAIDS. 2016. Prevention Gap Report. Geneva, Switzerland



- ii. to creatively market condoms as both pleasurable and safe;
- iii. increase the promotion of condoms amongst key populations especially MSM, transgender persons and sex workers.
- d. Condom interventions should be guided by evidence of where new infections are coming from, locations with high prevalence, populations with the highest HIV prevalence and to adolescents especially girls and young MSM.
- e. Condom interventions should integrate (and be integrated) into comprehensive sexuality education and efforts to promote respect for the right to the enjoyment of sex and to the expression of sexual identity.
- f. The use of both condoms and lubricants to prevent HIV must be promoted especially among young women and young MSM.
- g. Free or low cost female condoms should be widely accessible in both private and public sectors.
- h. Free or low cost condoms for oral sex and dental dams should be widely accessible in both the private and public sector.
- i. Condoms should be offered to all young persons who visit clinics and other health facilities with an STI or is pregnant.
- j. Condoms should be made available to prison inmates once they have an STI to prevent further transmission.

2.7.5. POSITIVE HEALTH, DIGNITY, AND PREVENTION (PHDP)

Positive Health, Dignity, and Prevention (PHDP) is an overarching term used for HIV prevention interventions among people living with HIV (PLHIV). Other terms that have been known to be used interchangeably include positive prevention, prevention with positives, prevention by positives, and prevention for positives. PHDP activities focus on the achievement of four key goals. These include: “(1) keeping PLHIV physically healthy; (2) keeping PLHIV mentally and psychologically healthy; (3) preventing transmission of HIV; and (4) involving PLHIV in HIV prevention activities, programme design, implementation and monitoring, leadership, and advocacy.”³⁶

People living with HIV (PLHIV) will continue to be a key target for prevention interventions. In particular, they should have access to prevention education, IEC/BCC and social and health services, whilst respecting their privacy and confidentiality.

- a. PHDP should be emphasised as a major strategy aimed at reducing HIV transmission. The Positive Health, Dignity, and Prevention Training Modules for Promoting Leadership Among Persons Living with HIV developed in 2015 should be delivered in a comprehensive and integrated manner for the adoption of safer sexual behaviours and practices among PLHIV.
- b. PLHIV should be actively involved in all efforts aimed at reducing HIV infection from design to evaluation.
- c. Prevention programmes for PLHIV must be designed and developed using a rights-based approach.

³⁶ Research to Prevention. Positive Health, Dignity, and Prevention Behavioural Interventions with PLHIV - Rigorous Evidence – Usable Results. Accessed at <http://www.jhsph.edu/research/centers-and-institutes/research-to-prevention/publications/positiveprevention.pdf>



2.7.6. TARGETED INTERVENTIONS WITH KEY POPULATIONS

Key populations based on the NISP 2014 – 2019 include MSM, transgender persons (TG), SW, homeless drug users and prison inmates. These populations are deemed more likely to be exposed to HIV infection due to sexual behaviour and high HIV prevalence within their social groups. The HIV prevalence in these groups is much higher than the general population and they contribute a significant proportion of new HIV infections.

- a. Key populations should be consulted in prevention programme planning, monitoring, and evaluation; prevention programmes should integrate human rights norms and principles.
- b. Surveys on the numbers, characteristics, prevalence and needs of key populations including risks associated with drug use, sex work, anal sex, homelessness and prison should be conducted.
- c. Information and education about sexually transmitted infections tailored to the needs of gender and sexual minorities (GSMs) should be provided at all health facilities in an environment free of stigma and discrimination.
- d. Support for safer sex practices to reduce risk of exposure to HIV should be provided to all GSMs.
- e. A comprehensive package of HIV-prevention services including access to condoms and lubricants; HIV counselling and testing; clear linkage to health care and antiretroviral treatment (ART); targeted information, education and communication (IEC); and Sexually transmitted infection (STI) prevention, screening and treatment must be developed and implemented.
- f. Public awareness campaigns must promote the inclusion of GSMs to decrease stigma and discrimination.
- g. Information for sex workers and their clients and others involved in the sex industry including reliable and affordable access to male and female condoms, lubricants and contraceptives must be promoted at all intervention sites.
- h. Transgender people should receive information about safer sex and how to protect themselves from HIV.
- i. HIV prevention programmes for transgender persons should be twinned with welfare, employment initiatives and housing in order to address the factors that make them more likely to engage in high-risk sex.
- j. Health workers, particularly primary care providers should receive training to understand and respond to the complex health and rights needs of transgender people.
- k. The efficacy of harm reduction programmes for persons who use drugs should be explored and information on the impact of drugs should be integrated in all HIV BCC messages.
- l. HIV-positive people who use drugs should receive parallel treatment and follow-up for their specific problems as well as for HIV.

2.7.7. HIV AND SRH-RELATED INTERVENTIONS FOR OTHER VULNERABLE POPULATIONS

This policy recognises that there are other vulnerable populations such as youth, women, persons with disabilities, persons aged 50 and over and other emerging marginalised groups that are exposed to HIV infection and most likely to suffer disproportionately from the negative consequences. The following groups should be given priority attention.

2.7.7.1. Women and Girls

UNAIDS (2012) highlighted that in general, women and girls face many interlinked socio-cultural, economic and legal challenges that make them vulnerable to HIV. The HIV epidemic exacerbates these issues making women and girls more vulnerable to violations of their human rights. There is need to invest in knowing, understanding and responding to the effects of the HIV epidemic on women and girls.



This policy supports the need for research that will give a greater understanding of the specific needs of women and girls in the context of HIV and to prioritizing actions that protect and promote the rights of women and girls. The policy also supports the following recommendations from UNDP:

- A comprehensive policy on sexual and reproductive health and rights including provisions for women living with HIV on freedom from sexual violence, forced abortion, and sterilization among other things should be developed and implemented.
- Gender-sensitive HIV training should be provided for health care providers, social workers, teachers, and judicial and law enforcement officers.
- Special initiatives aiming at the economic empowerment of women especially those living with HIV and AIDS should be implemented.
- Measures should be taken to adopt and implement a national strategy on gender and HIV to address sexual diversity among women and men and all factors that increase HIV vulnerability among women and men, and to ensure their access to comprehensive sex, health, and HIV education, and prevention, care, and support services
- Integrate a rights-based approach to sexuality, gender mainstreaming, and empowerment in the national development plan and National HIV/AIDS Strategic Plan.³⁷

In addition:

- Women should have the right to HIV-related services that are non-coercive and respectful of privacy, confidentiality and autonomy—including the right to consent or refuse services without being required to consult any other person or family member.
- Health Care Providers should address the overall health and specific psychosocial needs of women, particularly, older women and young girls, in the provision of counselling and other assistance.

2.7.7.2. *Persons Aged 50 and over*

Jamaica's elderly population (60 years and over) is the fastest growing age group. The dependent elderly (65 years and over) was estimated at 207,700 (7.8 %) in 2005 and by 2007, had grown to 223,961 (8.4%). Over the period 2007 to 2030, it is estimated that the elderly population will increase by 2.8 per cent to 11.2 per cent (321,664)³⁸.

The changing profile points to the need for increased programmes for the elderly. The aging of the population also has implications for HIV.

Based on 2015 data, 18.6% of the cumulative reported AIDS cases are between 50 and 94 years old. The 2014 WHO Global Update on the Health Sector Response to HIV highlights that there is a growing number of people aged 50 and over living with HIV. It indicated the need for HIV prevention and other services to respond to older people's needs.

- a. Research should be undertaken to gain greater understanding about the ageing process, how it impacts other illnesses and HIV-related treatment.
- b. Antiretroviral therapy (ART) should be integrated within care systems for other chronic diseases to facilitate the management of the PLHIV over 50 years old alongside other health issues such as diabetes, heart disease and hypertension.
- c. Media campaigns should specifically target sexually active persons over 50 years old

³⁷ UNDP, Jamaica. 2013.

³⁸ Planning Institute of Jamaica. National Development Plan Vision 2030



- d. Health-care providers should be trained to respond to the specific needs and challenges of persons over 50 years old.

2.7.7.3. *Adolescents*

Adolescents, especially girls, face significant barriers in accessing services that would prevent them from contracting STIs or becoming pregnant. Lack of access to comprehensive and accurate information on sexual and reproductive health means that adolescents are not equipped to manage their sexual health or to reduce potential health risks.

UNAIDS (2014) indicates that limited access to sexual and reproductive health services tailored to the specific needs of adolescents, including comprehensive sexuality education, can have a negative impact.

The Law and Policy Framework for Adolescent Sexual and Reproductive Health in Jamaica has recommended that policy makers “specifically address adolescent rights to education, freedom from violence and access to sexual and reproductive health as the basis for the policy directives.” (pg 29)

In 2003 Cabinet gave approval for the development of policy guidelines to establish a standard for provision of medical advice and services to adolescents. The guidelines sanction the provision of reproductive health information, counselling and services by health professionals to sexually active individuals under the age of 16 who cannot be persuaded to abstain from sexual activity, to involve their adult caregivers in the discussion with the health professionals and are judged mature enough to understand the implications of sexual activity. Additionally approval was received for the inclusion of other professionals (outside of health professionals) such as guidance counsellors in schools in these policy guidelines. It should be noted however that while these guidelines affirm the adolescents’ right to confidentiality and privacy and to access to information and services, as ‘policy’ they cannot override law. Current legislation prohibits any sexual activity among minors under 16 (as statutory rape under the Sexual Offences Act) and provides for the mandatory reporting of any such activity (under the Child Care and Protection Act). Work to address the major issues affecting adolescents is currently being addressed under the All In Programme. Notwithstanding, there is urgent need to scale up targeted prevention interventions to reduce HIV prevalence among adolescents especially among girls. Therefore:

- a. All girls and boys in and out of school should have access to comprehensive SRH and life skills education to enable them to protect themselves from HIV or to live positively with HIV if they are already infected.
- b. SRH information and services should be provided in line with the National Strategic Plan on Preadolescent and Adolescent Health and Development (2011 -2015) and the National Integrated Strategic Plan 2014 – 2019 and focus on the prevention of early pregnancies and STIs including HIV.
- c. SRH information should be integrated into HIV interventions and provided through life skills education programmes at all levels of formal and non-formal education settings.
- d. An integrated SRH and HIV curricula should be developed and promoted as an examinable subject at the primary and secondary school levels.
- e. Civil Society Organisations (CSOs) and other agencies should provide HIV prevention information, sexual and life skills education to out of school youth. Various platforms which are relevant to the populations of young people should be utilised including social media.
- f. Prevention interventions for adolescents should include mechanisms for improving livelihoods in order to reduce vulnerability among adolescents and young people.



- g. Prevention interventions for adolescents in and out of school should promote abstinence and or delaying sexual debut
- h. Counselling for reclaiming abstinence should be provided for adolescents in and and out of school who have already engaged in sexual intercourse.
- i. Abstinence interventions should be structured to prepare adolescents for their transition to becoming sexually active as adults. SRH information including condom use should therefore be integrated into abstinence initiatives.
- j. Sexually active adolescents should receive special attention to reduce their risk of STIs and pregnancies. All sexually active adolescents should have access to condoms and other commodities to prevent STIs and pregnancies.

2.7.7.4. People with Disabilities (PWDs)

Vision 2030 Jamaica - National Development Plan recognises Persons with Disabilities as a special group for legislative and social support. The Plan notes that PWD (especially older women) are at risk of several health problems, including, coercive sterilization and forced abortion. It pointed to inadequacies in reproductive health care and education and ignorance of contraception as major drivers of vulnerability among PWD. Sexual and physical abuse are also very high and often not reported. It is well documented that the vulnerability of persons with disability combined with a poor understanding and appreciation of their sexual and reproductive health needs, places them at higher risk of HIV infection (UNAIDS 2014b).

- a. Research should be undertaken to understand the SRH needs of PWDs and to ensure that HIV prevention services meet their needs.
- b. HIV prevention services should be made available and accessible to all PWDs without discrimination.
- c. All HIV-related prevention information, education and materials should be tailored for, and accessible to PWDs.
- d. Collection of data on disability and HIV must be prioritised. Data when collected must be disaggregated by type of disability, age, sex, sexual orientation and socioeconomic status.
- e. Scale up programmes that provide access to sexual and reproductive health services and information for persons with disabilities

2.7.8. BEHAVIOUR CHANGE COMMUNICATION (BCC)

A comprehensive BCC strategy that includes IEC is central to efforts to reduce the spread of HIV and the management of AIDS. BCC and IEC messages for the general population should therefore be scaled up. Since 2007 (the penultimate strategic period), there has been significant focus on prevention with key populations, specifically MSM and SW. The MoT (2012) indicates that whilst these populations account for a large percentage of new infections among their social groups, a significant amount was expected from those with low self-perceived risks. As such it is important that prevention activities among key populations are coupled with interventions among the general population to ensure gains are protected.

- a. All persons should have access to BCC and IEC on HIV and AIDS regardless of age, gender, sexual orientation or sexual behaviour.
- b. BCC material should be developed on a participatory basis so that they are tailored for key populations, the vulnerable and the general population. Material should also be tailored for schools and faith based organisations to ensure messages reach these key groups.
- c. BCC material should provide information that is scientifically accurate and evidence informed
- d. BCC material and messages should be grounded in ethical and human rights principles and should challenge stigma and discrimination in all its forms.



3. TREATMENT, CARE AND SUPPORT

This policy aims to reduce HIV-related morbidity and mortality in infected persons through increased HIV testing and counselling, the use of effective antiretrovirals, ART, effective linkage and referral, proper nutritional support, psycho-social and other support.

The policy recognises that HIV treatment, care and support services are integrally linked to prevention. This is because treatment, if implemented effectively, can result in reduced risk of transmission and a reduction in new infections.

5.1. Objective

Ensure universal access to treatment, care and support services for all without discrimination or barriers.

5.2. Main Policy Statements

1. Treatment must be provided or made available to all PLHIV without discrimination and any pre-conditions related to the person's behaviour, gender identity, orientation, legal or otherwise as per the Clinical Management of HIV Disease – Guidelines for Medical Practitioners 2017.
2. Factors that impede equitable access to treatment, care and support services, especially among key and vulnerable populations must be eliminated. These include barriers specific to, but not limited to: i) Persons with disabilities; ii) MSM and transgendered persons, sex workers, drug users, homeless persons; iii) Orphans and vulnerable children (OVC); iv) adolescents, including mothers; v) elderly persons; vi) mentally ill

5.2.1. HIV TESTING AND COUNSELLING (HTC)

HIV testing and counselling is an essential service in the HIV response as it is the entry point to the continuum of HIV prevention, treatment, care and support. HTC primarily involves individuals voluntarily seeking testing for HIV. Policies and practices related to HTC must be reviewed and the following scaled up and promoted: 1) provider initiated testing and counselling; 2) testing and counselling of all patients who enter hospitals; 3) community-based testing including home-based testing, mobile outreach in workplaces, schools, churches, community centres, pop up clinics and venues frequented by key populations; 4) point-of-care rapid testing by health workers.

- a. HTC should be routinely offered to individuals in clinical and non-clinical settings. This includes CSOs working with PLHIV.
- b. HTC should be routinely offered to all persons who attend an STI clinic and admitted to a hospital.
- c. Adequate information must be provided prior to testing and post-test counselling should be provided when test results are received. Clients who test positive must be made fully aware through counselling of their responsibility to prevent transmission to others.
- d. All HIV testing must be based on the "Three Cs" principles: informed consent, confidentiality and counselling. The result of any HIV test should not be disclosed by the service provider without the consent of the person tested.
- e. Policies and legislation that hinder access to HTC services for persons under 16 must be amended
- f. Guidelines for HTC among children under 16 years old must be fast tracked in order to get an accurate understanding of the epidemic among youth especially girls.
- g. HTC services should target youth and should be offered in settings that are youth friendly and non-judgemental.



- h. Strategies to increase men's uptake of HTC should be developed. This will include testing in settings that are more accessible/acceptable to men.
- i. Guidelines for HTC must emphasise and support disclosure. Couples and partner testing and counselling and mutual disclosure of status should be promoted as a risk reduction strategy. Persons who choose to participate in couple/partner testing should be given information about the pros and cons of disclosure.
- j. HTC services among key populations must be prioritised and promoted extensively based on the high prevalence rates. Structural, legal and social barriers – including stigma, discrimination, punitive laws and policies and vulnerable socioeconomic status act as barriers to testing key population groups.

5.2.2. LINKAGE AND RETENTION IN CARE

The referral of persons tested positive to HIV care and treatment in Jamaica has improved, but is still of concern – 25% of persons diagnosed with HIV infection were not linked to care. Of those linked to care, 67% have been retained in care in 2016. Adherence to treatment is also a challenge and drop-out and loss to follow up are major challenges in the health service delivery system – 43% of those diagnosed were on treatment and only 55% of those on treatment were virally suppressed. To address these key challenges, the policy proposes that as far as possible:

- a. Each person tested positive for HIV should be linked to treatment, care and support services within 30 days.
- b. Measures to improve patient monitoring systems with patient tracing options should be put in place
- c. Further decentralizing treatment and care services is crucial for strengthening linkages to treatment and care services. This will include increasing the number of treatment sites now available.
- d. An integrated approach to treatment should be promoted. This will include the provision of transportation and other related costs to increase testing and linkage to care and having services offered at one site instead of fragmented
- e. Promote linkages with NGOs and other civil society organisations to enhance linkage to care.
- f. Healthcare workers and administrative staff should be trained in sign language to be better able to communicate and provide service to persons in the deaf community.

5.2.3. ANTIRETROVIRAL THERAPY

There is currently no cure for HIV. A critical part of surviving HIV is through treatment. Antiretroviral therapy (ART) can stop persons from becoming ill for a very long time because it keeps the amount of HIV in the body at a low level. This policy indicates that:

- a. Measures are put in place to scale up equitable access to ART, STI and opportunistic infections treatment especially by key populations and youth.
- b. Treatment be administered in line with the standard updated WHO ARV guidelines.
- c. Guidelines for treatment should be widely disseminated to CSOs, health facilities, PLHIV networks to ensure accountability and transparency in ART.
- d. Use of ARV should be regulated and monitored to reduce the risk of drug resistance. CSOs should play an integral role in providing adherence support and mentorship for PLHIV.
- e. ART literacy should be promoted among all key populations and vulnerable groups.



5.2.4. *MANAGEMENT OF STIS*

Sexually Transmitted infections are considered the gateway to HIV. Persons with a history of STIs are more likely to become infected with HIV.

- a. This policy supports an integrated approach to responding to the epidemic. As such, it emphasises the need for the treatment of persons with reproductive tract infections and STIs. A syndromic approach to the management of STI patients should be promoted. “Syndromic management is based on the identification of consistent groups of symptoms and easily recognized signs (syndromes), and the provision of treatment that will deal with the majority or most serious organisms responsible for producing a syndrome”.³⁹
- b. Universal access to free, non-judgemental, comprehensive, confidential and client-friendly STI services must be provided to all regardless of age, gender, gender identity, sexual orientation, sexual behaviour, social, economic or political status. This should be done in accordance with existing STI management protocols or guidelines.
- c. Screening and treatment of reproductive tract infections and sexually transmitted infections among PLHIV should be scaled up
- d. Screening and management of cancer of the cervix and anus due to human papilloma viruses (HPV) among PLHIV should be scaled up and promoted.
- e. Epidemiological data from surveillance system will assist the Jamaican government to conduct efficient planning, monitoring and evaluation of interventions for STIs including HIV. The evidence-based information gathered is essential for effective decision making. Epidemiological surveillance by the MoH to monitor trends in the HIV epidemic is supported by this policy.
- f. Behavioural surveillance should continue to be conducted periodically among key populations and the general population to monitor the impact of interventions.

5.2.5. *ELIMINATION OF MTCT OF HIV*

Jamaica has made significant strides towards the elimination of mother to child transmission of HIV. However, with data indicating that 15% of HIV positive pregnant mothers are not being reached, the Government will need to scale up actions to ensure eMTCT programmes are available to every pregnant woman living with HIV. In line with World Health Organisation (WHO) PMTCT guidelines, Jamaica’s eMTCT of HIV programme is implemented in four prongs: (1) Primary prevention of HIV infection, (2) Prevention of unintended pregnancies among HIV-positive women, (3) Prevention of MTCT from HIV positive women during pregnancy, labour, delivery and breastfeeding and (4) Provision of treatment, care and support of HIV positive women. In view of the desired objective of eliminating MTCT of HIV in Jamaica:

- a. The routine testing of all pregnant women should continue and couple’s testing promoted.
- b. Establish minimum standards for the eMTCT of HIV programme to ensure proper management of the intervention. Standards should address nutritional support for mothers and family planning information
- c. Male involvement should be given special attention in the eMTCT of HIV programme. Efforts should be made to target the men with information on family planning/reproductive health, HIV and AIDS, STIs and to ensure that they support their partners during pregnancy, labour and after the birth of the child.
- d. Guidelines regarding disclosure to children by their parents and to their partners should be developed ensuring the rights of all concerned are observed.

³⁹ World Health Organisation. 2001 Guidelines for the Management of Sexually Transmitted Infections. Accessed at <http://apps.who.int/medicinedocs/en/d/Jh2942e/2.4.html>



5.2.6. BLOOD TRANSFUSION SAFETY

Transfusion of infected blood carries a very high risk of transmitting blood-borne diseases, including HIV and syphilis. It is essential that the National Blood Transfusion Service assures blood safety at all levels including time of donation, storage and transfusion. The elimination of blood-transmissible HIV infection should be facilitated by ensuring that health facilities obtain blood for transfusion that is screened for HIV and other transmissible infections and by promoting a voluntary blood donation programme.

- a. Blood safety from donation to transfusion should continue to be paramount. Mandatory laboratory testing of blood for donation will be maintained. The screening of donated blood should comply with internationally acceptable standards.
- b. The recruitment of potential safe blood donors should be voluntary through national drives, community outreach and in schools.
- c. The recruitment of blood from populations at high risk of HIV should not be promoted.
- d. An integrated approach to blood donation should be implemented whereby donations will be used as an opportunity to provide information on HTC and other prevention services.
- e. Mechanisms should be put in place and strictly enforced for donors who are tested positive to be linked to treatment, care and support services.

5.2.7. POST EXPOSURE PROPHYLAXIS (PEP)

Accidental exposure to, or increased risk of HIV infection can occur at home, at the workplace, in traumatic situations such as rape and accidental exposure during consensual intercourse. Post-exposure prophylaxis (PEP) is short-term antiretroviral treatment to reduce the likelihood of HIV infection after possible exposure, either occupationally or through sexual intercourse. Evidence shows that using antiretroviral (ARV) drugs can reduce the risk of HIV infection by over 80%.⁴⁰ Universal precautions are an integral part of good health practice. This policy promotes effective measures to protect healthcare workers against the risk of HIV infection. The policy supports the development, dissemination and use of protocols in health facilities and the training of healthcare workers (HCW). The following basic principles are to be considered:

- a. PEP services should be provided in accordance with existing national and international guidelines.. These services should be available and accessible to all in need and at all times at all health facilities.
- b. Guidelines for the practice of universal precautions for infection prevention and control should exist in all health facilities.
- c. PEP should be offered to all persons who come in contact accidentally, including survivors of sexual violence.
- d. Materials, equipment and supplies for universal precaution must be available in all health facilities at all times.

5.2.8. OPPORTUNISTIC INFECTIONS

PLHIV co-infected with other STIs, tuberculosis (TB), malaria, hepatitis and other diseases which, if left untreated could adversely affect their response to ART, should be offered specific treatment regimens in addition to ART. As specified in the National Guidelines⁴¹, ART is offered regardless of CD4 count in four categories: pregnancy, active Tuberculosis, hepatitis B requiring therapy, and HIV associated nephropathy. Individuals with co-infections should be prioritised for treatment and not denied treatment based on the presence of co-morbidities.

⁴⁰ World Health Organisation. 2014. Fact Sheet: Post-exposure Prophylaxis to prevent HIV. <http://www.who.int/hiv/topics/prophylaxis/info/en/>

⁴¹ Ministry of Health, Jamaica. 2013. Guidelines for the Clinical Management of HIV/AIDS



6. ENABLING ENVIRONMENT AND HUMAN RIGHTS

6.1. Introduction and Rationale

Human rights violations and related stigma and discrimination of persons infected with or at high risk of infection is pervasive in Jamaica. An enabling human rights and legal framework, free from discrimination and which supports various biomedical, social, psychosocial and economic approaches is favoured to promote and protect the rights and empowerment of PLHIV, as well as key and vulnerable populations. The right to health is an inalienable right.

Whilst Jamaica has made progress in developing or amending laws, policies, guidelines and protocols to create an enabling environment for the HIV response, barriers to the successful implementation of these policies and guidelines remain. These barriers include social norms, cultural factors, gender inequality, laws, domestic and gender-based violence and pervasive stigma and discrimination continues to make it difficult for persons to protect themselves from HIV infection and to seek treatment.

The realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV and AIDS. Respect for the rights of people living with HIV is an essential and central component of an effective response. Discrimination against people living with HIV and AIDS and key populations violates their rights and is counterproductive to an effective and enabling response. People living with HIV also have a responsibility to respect the rights and health of others.

The Policy supports efforts by the Ministry of Health through the National Family Planning Board and the Ministry of Labour to:

1. Amend the Public Health (Class 1 Notifiable Diseases) Order 2003 - This Order classifies HIV and AIDS as a notifiable disease and as a communicable disease. Although HIV is a communicable disease, it is not contagious. Persons living with HIV and AIDS have experienced discrimination because persons have interpreted communicable as contagious. It is being recommended that the provisions relating to communicable diseases in Public Health Regulations or in the Education Act should not apply to HIV and AIDS. HIV and AIDS should remain in the classification of notifiable diseases for the sole purpose of surveillance and reporting.
2. Support the integration of the redress aspect of the National HIV Related Discrimination Reporting and Redress System (NHDRRS) into existing redress entities.
3. Support HIV Regulations needed to support the National Workplace Policy on HIV/AIDS within the context of a proposed Occupational Safety and Health Act (OSH)⁴².

The policy statements and strategies outlined in this document have been culled from the National HIV Policy 2005, the National Strategic Plan 2012 – 2017, the National Integrated Strategic Plan for HIV and SRH 2014 – 2019 and the UNAIDS Gap Report 2014. The statements cover PLHIV, Positive Health Dignity and Prevention, Key Populations, the Workplace Policy and Legislative Framework.

6.2. Objective

To promote respect for human rights in dealing with HIV and AIDS issues at policy and programme levels.

⁴² Retrieved from <http://www.nhpjamaica.org/enabling-environment-and-human-rights>.



6.3. Main Policy Statements

1. The Government of Jamaica is obligated to respect, protect and the fulfil the rights of all persons with regard to SRH and HIV, including the right to information, treatment, privacy and confidentiality.
2. Laws, policies and guidelines to protect the rights of PLHIV, children and key population groups, including protection against any form of stigma and or discrimination should be revised in keeping with international best practices
3. Government must amend laws, policies and practices that increase stigma and discrimination on the grounds of sex, sexual orientation and gender identity.
4. Government must set high standards in health care services to ensure that health care workers are properly trained and that the rights of clients – including youth and those from key and vulnerable populations – are respected.
5. PLHIV must be protected from arbitrary or unlawful interference with their privacy. Therefore, medical and personal information is subject to strict rules of data protection and confidentiality.

6.3.1. POLICY AND LEGISLATIVE FRAMEWORK

- a. The legal framework facilitating the implementation of this policy should be in compliance with Jamaica's Constitution, Vision 2030 Jamaica - National Development Plan and international conventions, treaties and declarations signed and ratified by the country.
- b. Government should facilitate the review and amendment of existing laws⁴³ and facilitate the passing of new laws to ensure that the law adequately addresses the public health and human rights issues related to HIV prevention, treatment, care and support.
- c. Specifically, government should facilitate the review and amendment of the Charter of Fundamental Rights and Freedoms to include protection against discrimination based on health including mental illness, gender identity and sexual orientation
- d. The Enabling Environment and Human Rights Unit of the National Family Planning Board should provide access to information on legal services available to PLHIV and key population groups to support access to legal services. Legal literacy and legal aid services should be provided for PLHIV and key population groups. The groups should know their legal and human rights and be supported to access justice through legal aid services.
- e. Training of police, lawyers, judges, public health workers and other public officials on human rights issues should be scaled up to create a more enabling environment for the HIV response.
- f. Policy monitoring mechanisms to report on incidences of rights violations, including discrimination, gender-based violence, issues with policing of key populations, violations of informed consent, violations of medical confidentiality, denial of healthcare services, among others should be implemented.
- g. Develop and implement a sexual and reproductive health policy with an exemption clause to allow access to prevention services by minors and the provision of such services by healthcare professionals without fear of prosecution⁴⁴.

⁴³ J. Chan in Legal Reforms, Social Change: HIV/AIDS, Human Rights and National Development in Jamaica provide an overview of laws that need to be revised. These include The Law Reform (Age of Majority) Act, Offences Against the Person Act and Sexual Offences Act. Additionally she makes the case for 'a comprehensive and enforceable anti-discrimination law that would ensure the legal protection of PLHIV in all aspects of life including employment, education, housing, social support etc.

⁴⁴ Ibid



6.3.2. CONFIDENTIALITY AND DISCLOSURE

This policy recognises that individuals should enjoy their right to privacy and confidentiality around their HIV status.

- a. Information about the HIV status of an individual must not be disclosed without the informed consent of the PLHIV.
- b. A PLHIV cannot be forced to disclose his or her HIV status except when required by the law. Other exceptions include:
 - HIV is a reportable disease under the Public Health Act. Guidelines for the sharing of information among health and other professionals are in place and should be followed⁴⁵.
 - HIV status must be disclosed to a healthcare provider who is directly involved in providing care to the PLHIV, where knowledge of the persons' HIV status is necessary to make clinical decisions in the best interest of the person
 - For epidemiological data collection where the release of information will not directly identify the person to whom it relates
 - A court order, where the information contained in the medical file is directly relevant to the proceedings before the court.
- c. There should be strict enforcement of existing codes of conduct of professional bodies to discipline breaches of confidentiality and unreasonable invasion of privacy as professional misconduct.
- d. Health care workers should undergo preservice ethics and/or human rights training including confidentiality guidelines.
- e. Guidelines for the voluntary disclosure of positive HIV status between sexual partners should be developed and promoted. Particular attention must be given to the fact that disclosure may result in violence or other actions that put the PLHIV at risk of physical violence.⁴⁶
- f. Guidelines that outline how, when and to whom beneficial disclosure by a healthcare worker may be made should be developed and implemented. This should be done in accordance with internationally accepted protocols and should include counselling.
- g. Information on the HIV status and any related healthcare procedures of a PLHIV in detention or in state care should be treated with confidentiality.
- h. The right to privacy of the individual or group of persons as regards HIV and AIDS must be respected in the print and electronic media.
- i. Data on HIV and AIDS cases reported for epidemiological purposes must be subject to strict rules of data protection and confidentiality.

6.3.3. PROTECTION OF PLHIV

- a. The HIV status of a person should not form the basis for denial of health care and employment. This is a violation of the person's rights.
- b. Persons who contract HIV through illegal or perceived illegal conduct should be able to seek healthcare without fear of being reported to law enforcement agents.
- c. Ministries, Departments and Agencies of Government, should put in place policies that effectively address discrimination on the basis of HIV and AIDS status and take steps to effectively eliminate stigmatisation and discrimination in their institutions and in the implementation of their sectoral mandates.
- d. The HIV status of an individual should not put him/her at a disadvantage to obtain personal or group health insurance.

⁴⁵ Ministry of Health, Jamaica. 2012. Guidelines for HIV Case-based Surveillance

⁴⁶ Accessed from http://data.unaids.org/pub/Manual/2007/20071128_ipu_handbook_en.pdf



- e. Mechanisms should be put in place to improve the participation of PLHIV in the planning, development, implementation, monitoring and evaluation of HIV programmes
- f. The National HIV-Related Discrimination Reporting and Redress System (NHDRRS) should be reviewed and revised to ensure that PLHIV whose rights have been infringed have access to independent, speedy and effective legal and/or administrative procedures for seeking redress.
- g. PLHIV should have access to low cost medication and SRH commodities to protect themselves from re-infection and protecting others from infection.

6.3.4. PROTECTION OF PEOPLE WITH DISABILITIES (PWDs)

- a. HIV services should be made available and accessible to all PWDs without any form of discrimination
- b. The national HIV response should take into consideration the needs of PWDs and plan for more effective responses based on evidenced-informed international practices and in accordance with the Disability Act 2014.
- c. All interventions targeting PWDs should be developed with the full participation of PWDs.
- d. Mechanisms should be put in place to ensure that HIV-related prevention information, education, treatment, care and support strategies and materials are tailor-made for, and accessible to PWDs.
- e. All PWDs should be protected from abuse that leads to increased risk of contracting HIV.

6.3.5. PROTECTION OF KEY POPULATIONS AT RISK

Key population groups include MSM, SWs, people who use drugs, homeless persons and prison inmates. This policy supports recommendations that healthcare providers, beneficiaries of HIV prevention drug treatment, harm reduction and non-medical service providers who provide assistance to key populations should not be considered as accessories in the prosecution of key populations.

The policy also provides that health care workers, civil society workers or other individuals engaged in the distribution of educational materials about disease transmission risks, drug treatment and harm reduction should not be considered as aiding and abetting criminal offences.

6.3.5.1. MSM

- a. The sexual orientation or a gender identity of a person should not form the basis for denial of health care and related services.
- b. Mechanisms should be put in place to ensure that HIV and STI prevention, treatment, care and support services can be accessed by MSM without discrimination.
- c. Guidelines should be put in place for a human rights-based approach to ensure MSM receive access to appropriate, quality health services and which guarantees their privacy and confidentiality.
- d. Steps should be taken to decriminalize private, consensual same-sex conduct and to repeal discriminatory laws relating to sexual orientation and gender identity.
- e. Mechanisms should be put in place to provide treatment literacy, legal literacy, and capacity building training for MSM to demand their rights, take personal responsibility, and participate effectively in HIV policy-making.
- f. Health care workers and other professionals that come in contact with MSM should undergo minimum ethics and/or human rights training including on privacy and confidentiality issues.
- b.



6.3.5.2. *Sex Workers*

- a. Engaging in sex work should not form the basis for denial of health care and related services.
- b. Mechanisms for income-generating activities that attract SWs and provide them with alternative income sources should be established and promoted.
- c. Appropriate regulatory frameworks within which sex workers can enjoy safe working conditions should be developed.
- d. Sex workers should have access to treatment literacy, legal literacy, and capacity building training that will allow them to take personal responsibility, and participate effectively in reducing the HIV epidemic.

6.3.5.3. *Transgender Persons*

Transgender people are 49 times more at risk of living with HIV compared to the general population. They often face social and legal exclusion, economic vulnerability, and are at an increased risk of experiencing violence. Low self-esteem and lack of power make transgender women, in particular, less likely or less able, to negotiate condom use. Therefore:

- a. Programs providing care for transgender persons should involve basic standardized assessments to identify associated social challenges, mental health, substance use, and HIV risks.
- b. Health workers, particularly primary care providers should receive training to understand and respond to the complex health and rights needs of transgender people.
- c. Health care workers should create a safe and inclusive environment for transgender persons
- d. Transgender persons should have access to treatment literacy, legal literacy, and capacity building training that will allow them to take personal responsibility, and participate effectively in reducing the HIV epidemic.
- e. Programmes, policies and guidelines for transgender persons should be gender affirming, aimed at supporting them to live congruent with their gender identity.

6.3.5.4. *Prison Inmates*

Prison inmates are a key population for the spread of HIV to the general population once discharged. It is therefore important that HIV prevention, treatment, care and support services are available within the prison system.

- a. The Ministry of National Security through the Correctional Services Department should develop and implement strategies, policies and programmes that respect, protect and fulfil the human rights of prisoners and service personnel.
- b. The full range of HIV services should be provided to infected and non-infected persons who are incarcerated. This includes access to prevention services (SRH education, information and commodities and HTC); treatment – including ART and care and support.
- c. Condoms should be made easily and discreetly accessible to prisoners so that they can pick them up at various locations in the prison, without having to ask for them and without being seen by others⁴⁷.
- d. Female prisoners should have access to gender-sensitive HIV and STI prevention and treatment services.
- e. Mechanisms should be put in place to ensure that on release from prisons, persons are connected with CSOs and health facilities for continued treatment and care.

⁴⁷ UNDP, 2013. Legal Reforms, Social Change: HIV/AIDS, Human Rights and National Development in Jamaica.



- f. Prison authorities should take all necessary measures, including adequate staffing, effective surveillance, and appropriate disciplinary measures to protect prisoners from rape, sexual violence and coercion by other prisoners and by warders.
- g. Prisoners who are victims of rape and sexual violence should have timely access to PEP. Appropriate systems must also be in place for complaint and redress.
- h. The Ministry of National Security and the Department of Correctional Services should ensure that the training curricula for police and Correctional Service employees are strengthened to include: Ethics and human rights, including consent and confidentiality; Stigma and discrimination; Gender-based violence; Human sexuality and the specific needs of key and vulnerable populations; SRH and HIV

6.3.5.5. Persons who use drugs

- a. Engaging in drug use should not form the basis for denial of health care and related services to persons who use drugs.
- b. Harm reduction should be an integral part of the national HIV response and based on relevant measures suggested by UNAIDS.
- c. Guidelines should be put in place outlining human rights based approach to the treatment and care of persons who use drugs and are HIV positive.
- d. Current HIV prevalence data among homeless drug users should be disaggregated by gender, MSM, sex and drug users.

6.3.6. CHILDREN AND YOUTH

- a. Ensure non-discrimination of children living with HIV in education with a redress mechanism through a comprehensive general anti-discrimination law and/or amendment in the Education Act.
- b. Activate the review of the Management of HIV/AIDS in Schools Policy focusing on HIV-related stigma, violence, and discrimination in the community, the needs of orphans and vulnerable children affected by HIV/AIDS, and gender-related issues relevant to HIV and AIDS.
- c. Provide HIV and anti-discrimination training among school personnel.
- d. Ensure coordination, communication, and accessibility of youth and HIV and AIDS research through an online database.
- e. Align different SRH provisions in existing legislations and policies⁴⁸

6.3.7. PROTECTION IN THE WORKPLACE

- a. Using the National Work Place Policy as a guide, all public and private sector workplaces should develop and implement HIV and AIDS workplace policies and programmes through the participation of both employers and employees.
- b. All public and private sector workplace policies should indicate that HIV testing is not be a precondition for employment.

⁴⁸ J. Chan notes there is a great deal of confusion and conflicting directions between the Law Reform (Age of Majority) Act, Offences Against the Person Act, Sexual Offences Act, the Child Care and Protection Act, and the Access to Contraceptives Policy for Minors.⁹² Under the Law Reform Age of Majority Act, a child at age 16 can consent to 'any surgical, medical or dental treatment', including diagnostic and ancillary procedures. The consent of the parent or guardian of a child aged 16 or older is not required for such treatment/procedure.



7. MITIGATION OF THE SOCIAL AND ECONOMIC IMPACTS OF HIV AND AIDS

7.1. Introduction and Rationale

Various international studies point to the devastating social and economic impacts of the HIV epidemic on individuals, families, communities and countries at large. These include decline in productivity, increase in the numbers of orphans and vulnerable children, increased poverty, declines in the educational outcomes for OVC, low attendance at school for OVC among others. This policy recognizes that the protection and empowerment of PLHIV and other vulnerable populations are critical to efforts that seek to minimize the impact of the epidemic.

The main mitigation efforts include the reduction of stigma and discrimination against PLHIV, key and vulnerable populations; addressing the impact of gender norms and stereotypes; addressing the impact on households and caregivers; and access to basic needs for PLHIV, orphans and vulnerable children. Other issues addressed by this policy include counselling and emotional care for HIV infected and affected persons.

7.2. Impact Mitigation Objective

Alleviate the social, cultural and economic effects of HIV and AIDS at individual, household and community levels.

7.3. Main Impact Mitigation Policy Statements

1. PLHIV and other vulnerable groups have the right to adequate standards of living, including equitable access to social protection and other forms of material assistance, particularly in the event of unemployment, sickness, or disability^{49 50}.
2. Mechanisms to mitigate the impact of HIV and AIDS on poverty and social security must be implemented alongside prevention and treatment interventions.
3. Measures to improve the psychological impact of HIV on PLHIV and key population must be developed and implemented.

7.3.1. SOCIAL PROTECTION

- a. Mechanisms should be put in place for assisting PLHIV, women and girls, OVC and households made vulnerable by HIV and AIDS to access social protection schemes such PATH.
- b. The Enabling Environment and Human Rights (EEHR) Division Unit of the National Family Planning Board should provide information on social protection programmes available to PLHIV and key population groups and how to access them.
- c. The EEHR Unit should partner with CSOs to increase the number of PLHIV and key population groups who have access to and utilise existing social protection programmes
- d. Guidelines are to be developed for the identification and referral for food and other basic care items of OVC to appropriate poverty reduction programmes.

⁴⁹ ABA ROLI HIV/AIDS Legal Assessment Tool, http://www.americanbar.org/content/dam/aba/directories/roli/misc/aba_rol_i_hiv_aids_legal_assessment_tool_11_12_authcheckdam.pdf.

⁵⁰ UNDP, Jamaica. 2013. HIV and AIDS Legal Assessment Report for Jamaica



- e. Partnerships with the Ministry of Labour should be sought to develop a framework for sustainable income-generating activities to enable women, girls and PLHIV to cope with the impact of HIV and AIDS.
- f. PLHIV and key population groups should not be denied access to social protection based on the HIV status, employment status or sexual orientation.
- g. Plans should be put in place for a Poverty Reduction Strategy and Action Plan for PLHIV

7.3.2. GENDER EQUALITY AND EQUITY

- a. Government through the National Family Planning Board and the National HIV/STI/TB Unit should take measures that will integrate, promote, improve and protect the sexual and reproductive health rights and health status of men, women, boys and girls.
- b. All HIV programmes, policies and action plans should take into consideration issues of gender in terms of access for all population groups.
- c. Government should create an enabling environment where women, men, boys and girls are protected from all forms of violence including sexual violence that may negatively affect health.
- d. BCC interventions should integrate gender norms that impact negatively on reproductive health and HIV prevention.
- e. All HIV prevention services and programmes should be accessible by women, men, boys and girls on an equitable basis.
- f. HIV prevention programmes should focus on empowering women with negotiation, self-assertive and livelihood skills. This will allow women to make good decisions about their sexual and reproductive health and rights and to negotiate for safer sex with their partners.
- g. Increased efforts should be made to encourage the participation of men in HIV programmes.
- h. Government through the Enabling Environment and Human Rights Unit of the National Family Planning Board should take measures to integrate, promote, improve and protect the sexual and reproductive health rights as well as the health status of men, women, boys and girls.
- i. The rights of women, men, boys and girls to have control over their own bodies, and to make decisions free of discrimination on matters related to their sexual and reproductive health should be protected.
- j. The Government should collect and use sex and age-disaggregated data to monitor and evaluate the impact of programmes on different populations
- k. Government should ensure meaningful participation of women, men, PLHIV, key and vulnerable populations in the planning, design, implementation and monitoring of programmes
- l. Government should support programmes that focus on strengthening the role of parents and guardians in shaping positive attitudes and the behaviour of children and young people as regards sexuality and gender norms in the context of HIV and AIDS, STIs.

7.3.3. PROTECTION OF OVC

- a. The National Plan of Action for Orphans and Other Children Made Vulnerable by HIV/AIDS in Jamaica 2003 – 2006 should be revised and updated in keeping with current International Best Practices
- b. Guidelines for the care of OVC by families and the State should be developed and implemented.
- c. Guidelines and minimum standards of care should be developed for OVC in state care to ensure that they are not abused.
- d. Existing legislation to protect children and young people against any form of abuse or exploitation should be strengthened and enforced.



- e. Programmes that strengthen the capacity of parents/guardians to care for OVC should be prioritised.
- f. All OVC should have access to education and resources identified to address barriers to school attendance such as fees, cost of books, supplies and uniforms.

7.3.4. PROTECTION FOR THE AGED

- a. The Government of Jamaica should invest in research on the ageing process and how other chronic illnesses may affect HIV-related treatment. It should provide concrete support for older people living with HIV, such as access to nutrition.
- b. Healthcare providers should be trained on ageing and issues of ageing and HIV and AIDS to enable them to provide psychological and medical support for older people living with HIV.
- c. Older people should be included as part of the target group in HIV and AIDS education training programmes.
- d. HIV services for persons, aged 50 and older should be integrated with other chronic health services such as diabetes, heart disease and hypertension.

7.3.5. PSYCHOLOGICAL AND EMOTIONAL SUPPORT

- a. Counselling and other care services for HIV infected and affected persons should be strengthened and expanded through public-NGO partnerships.
- b. Support groups for PLHIV and key population groups should be revitalised and expanded.



8. HEALTH SYSTEMS STRENGTHENING

8.1. Introduction and Rationale

Jamaica's high debt payments (estimated at 56% of the national budget) is a strain on health sector spending and leaves very little fiscal space to scale up HIV prevention and treatment. The current IMF agreement compounds the challenges within the health sector as there is a freeze on human resources. This has implications for the optimal performance of the health sector.

The Economic and Social Survey 2014 highlights various measures introduced towards Health Systems Strengthening. These include the abolition of user fees, introduction of GOJ Health Card in 2013 and the Electronic Patient Administration System (e-PAS) in 2014 among others. There however remain many challenges that impact the effectiveness of the national HIV response.

The "no user fee" policy has resulted in an increase in the use of public health facilities thus increasing the demands on the health system. UNDP (2013) highlights significant gaps including "delays in and under coverage of testing and treatment, breach of privacy and confidentiality; human resource bottleneck including insufficient pharmacists, doctors, and nurses; poor data management system (absence of an electronic medical system); and a lack of psychosocial support for patients."

A 2014 Human Resource Analysis for HIV services revealed that overall, the full time equivalent (FTE) of currently deployed health care workers is 62% of the optimal level required with the gap between current and optimal level being different across various staff cadres with support providers having the largest gap.⁵¹

8.2. Health System Strengthening Objective

Ensure strategies, resources and inputs for HIV and AIDS are integrated within the health system to enhance overall efficiency.

8.3. Health Systems Strengthening Statements

8.3.1. LEADERSHIP AND GOVERNANCE

- a. The Ministry of Health, through the National HIV/STI/TB Unit and the National Family Planning Board should guide prevention, treatment, care and support services, as well as strategic information such as surveillance data for action.
- b. The MoH should provide an enabling policy environment that allows for collaborative partnerships in the health sector and with other MDAs, the private sector and nongovernmental organisations (NGOs).
- c. The MoH should partner with key stakeholders to foster a multi-sectoral collaboration to improve health and non-health outcomes in the HIV and AIDS response
- d. The MoH should ensure transparency and accountability of key stakeholders in the national response through monitoring and supervision.

⁵¹ Jamaica Proposal to the Global Fund 2015.



8.3.2. HUMAN RESOURCES

- a. Evidence points to the gap between current and optimal levels of health care workers widening in the next five years as a result of high patient load. The Government of Jamaica should invest in the recruitment, training and retention of adequate numbers of staff with equitable distribution in areas with high burden of HIV to ensure an effective and efficient national HIV response.
- b. The MoH should partner with civil society organisations to enable the latter to provide support to deal with PLHIV and key populations without compromising quality or increasing risk to clients and patients.
- c. All health care workers should undergo minimum ethics and/or human rights training including confidentiality guidelines.

8.3.3. SERVICE DELIVERY

- a. An integrated HIV/SRH approach should be followed throughout all health system and primarily at the level of service provision.
- b. The MoH should invest in the establishment of a strong linkage and referral system that will allow for the full range of services available at each treatment site. This includes access to quality health services such as HIV, STI, TB, family planning, PMTCT, child health and psycho-social support being offered to clients on the same day.

8.3.4. SUPPLY MANAGEMENT

- Government and the relevant departments and agencies should ensure timely access to essential medical products that are of assured quality, safety and efficacy and cost-effective for PLHIV and key populations.
- Government should invest in a Health Management Information Systems that provides adequate information on stock management and support forecasting of ARV and SRH commodities in order to prevent stock outs.
- Guidelines should be developed to implement a robust system that carries out appropriate studies to monitor the emergence of ARV drug resistance.

8.3.5. RESEARCH AGENDA

SRH, HIV and AIDS research is required to address gaps in existing knowledge about HIV and to inform policy, practice and HIV-related interventions. The following strategies should be implemented to further the research agenda.

- a. Promote epidemiological, biomedical, social science and operational research in order to provide sound, scientific and reliable information to guide national HIV policy, practice and interventions. All HIV-related research involving human subjects should satisfy ethical and human rights considerations according to the standards of international best practices whilst respecting national cultural sensitivities and norms.
- b. Strengthen the capacity of research bodies to conduct HIV-related research.
- c. Promote wide and timely dissemination of national and international HIV research results.
- d. Encourage the collaboration of international HIV and AIDS researchers with local institutions.
- e. Promote genuine community and stakeholder participation in the planning, execution and oversight of research involving human subjects.
- f. Promote collaboration with academic institutions and institutional research partners to conduct sophisticated research in all aspects of HIV and AIDS including basic science and prevention, clinical and HIV vaccine trials.





9. COMMUNITY SYSTEMS STRENGTHENING

9.1. Introduction and Rationale

Community Systems Strengthening (CSS) seeks to build the systems, policies and frameworks which can improve the human rights, socio-cultural, organizational and community issues which affect access to health and social services by persons living with HIV, key and vulnerable populations.

It is critical that a systematic, robust and harmonized approach to partnership between and among health facilities, community-based organizations and community actors is developed and implemented to ensure the elimination of HIV.

At present, most CSOs operate in the Kingston Metropolitan region. A recent baseline assessment of NGOs which provide service for the LGBT community, for instance, indicated that only one NGO provided exclusive services to these populations and it is Kingston based. Additionally, whilst a PLHIV coordinating body is in existence, it is challenged with limited coverage and capacity to address the needs of the PLHIV community. A lack of human resources, limited financial resources and the need to improve the organizational capacity of CSOs, through documented systems and protocols such as referrals systems to provide the framework for care and support for clients who access services, were reported to also affect the efficacy of service delivery.

CSS will promote the development of effective and supportive communities for PLHIV, key and vulnerable populations and community-based structures that enable them to contribute to the sustainability of the HIV response. It should lead to improved health monitoring and will improve the involvement of the community-based organisations in HIV treatment. CSS will improve access to and utilisation of formal health services and will also increase community engagement in prevention and social care, advocacy and policy and human rights monitoring.

9.2. Community Systems Strengthening Objective

Improve the responsiveness and effectiveness of interventions by communities in health, social support and other services.

9.3. Community Systems Strengthening Statements

- a. Community actors and health actors should collaborate to develop and manage systems that they will use jointly to deliver activities and services for communities. This will result in outputs that lead to improved health outcomes as well as improvements in the treatment of those most affected by HIV.
- b. Key actors in community systems should include faith-based organisations, volunteers, NGOs and CBOs. Other key actors should include health personnel who provide treatment, community health and prevention interventions. Key sector players should be from education, private sector, national development, labour, justice and security sectors.
- c. Programmes in the community should be evidence-based, sustainable and aligned to Vision 2030, the National Strategic Plans and other international commitments. They should include counselling, legal support, policy/legislative advocacy, prevention, treatment and building awareness around issues affecting PLHIV and key populations.



- d. Community systems should collaborate with partners in the health system around stigma reduction programmes, treatment literacy and education to alleviate discrimination.
- e. Networks, linkages, coalitions and partnerships should be encouraged and supported. This will result in shared approaches, advocacy initiatives and appropriate representation of community needs in a co-ordinated and collaborative environment. This could be done through the Civil Society Forum on HIV and AIDS. Structured partnerships will lead to more effective use of resources and avoid duplication.

9.3.1. CAPACITY BUILDING

Capacity building of CBOs and NGOs is vitally important for the development of an enabling and responsive environment that will result in improved outcomes for health and well-being, respect for people's health, other rights and protection from social and financial risk. As such:

- a. Funds for specific operational activities and services in communities should include operational and core funding, as well as material resources for infrastructure, information and SRH and other commodities and technologies.
- b. Capacity-building programmes for stakeholders engaged in CSS programmes should include training for management; results based management; paralegal skills to enable community actors to support clients in understanding and articulating their human and legal rights; policy monitoring in order to have community monitor policy and data collection and documentation on human rights issues to guide evidenced-based human rights advocacy interventions
- c. Community actors should be supported in regularising their legal status and conducting independent audits of finances.
- d. The MoH through the NHP and NFPB should develop guidelines for community-level HIV prevention, treatment, care and support activities in order to facilitate the systematic development of CSS programmes and implement joint community-level strategies.



10. IMPLEMENTATION FRAMEWORK

10.1. Management and Coordination

A strong and well-defined coordination and management mechanism is needed for an effective multi-sectoral response. Coordination will ensure a harmonized service delivery mechanism and increased collaboration and cooperation amongst key players. Coordination of the multi-sectoral national response shall be facilitated and promoted at national, regional and parish levels and through various sectors. It is therefore imperative that institutional capacity building is ensured for the execution of this policy.

The Government of Jamaica will implement the policy in partnership with civil society, including the private sector, NGOs, CBOs, FBOs and other stakeholders. In addition to this multisectoral approach, the implementation of the policy will be participatory, such that it will involve all beneficiaries including persons living with and affected by HIV and key population groups in the design, delivery and evaluation of the programme.

The National Family Planning Board and the National HIV/STI Programme (Ministry of Health) have responsibility to lead the coordination of the national response, provide leadership and technical guidance, and address the mobilization of adequate local and international resources for an effective response to the epidemic.

Ministries, Departments and Agencies (MDAs), NGOs and private sector entities will implement various aspects of the policy.

Strengthening and sustaining partnerships between the Government and all relevant stakeholders is critical to the success of the policy. The National AIDS Committee (NAC) will continue to be, a key player in this regard as its members represent inter alia the tripartite team of government, employers and workers, the vulnerable population including PLHIV, the donor community, the private sector and civil society.

10.2. Institutional Framework for Implementing the HIV Policy

The effective implementation of this policy requires strong political will, leadership and commitment. The institutional arrangements will therefore call for the establishment and or strengthening of working groups to augment management and coordination of the national response.

Implementing the HIV Policy will be multi-sectoral. It is premised in the acknowledgement that the pursuit to end AIDS by 2030 will require all hands on board. All sectors in the public and private sectors have a role to play in the implementation of this policy. Institutions are expected to identify entry points and opportunities for networking and collaboration to ensure synergy and maximum impact in addressing the HIV epidemic in Jamaica.

The enforcement of the “three ones” principle; utilising the UNAIDS investment framework; the allocation of specific roles and responsibilities to all stakeholders; commitment to legislative reform; resource mobilisation and tracking and monitoring and evaluation are other key components of institutional arrangements.

The institutions that will play a key role are listed in the framework below.



10.2.1. INSTITUTIONAL FRAMEWORK MATRIX

The matrix below outlines the generic roles and responsibilities for institutions at all levels in the implementation of the HIV Policy.

Table 1: Institutions and their role and responsibilities

INSTITUTIONS	ROLES AND RESPONSIBILITIES
Ministries, Departments and Agencies (MDAs)	
As the largest employer, the government has a responsibility to provide and increase access to prevention education, to treatment and care; and to set up structures and systems to reduce HIV-related discrimination. Key government ministries in the national response include the Ministry of Health; Ministry of Education, Ministry of Youth; Ministry of Finance and Planning; Ministry of Labour and Social Security; Ministry of Tourism and the Ministry of National Security.	
Ministry of Health	<ul style="list-style-type: none">- Establish appropriate mechanisms for coordinating and leading the implementation of the national HIV and AIDS response- Provide technical support on HIV and SRH to other government institutions, civil society organisations and the private sector- Set standards, develop guidelines, disseminate and monitor their operationalisation- Provide technical guidance and assistance for the implementation of biomedical interventions- Continue with the implementation of health sector-based interventions to prevent the sexual, blood-borne and mother-to-child transmission of HIV.- Coordinate and provide HIV treatment services through the public health system at the national, regional and parish levels;- Drive institutional capacity building and infrastructure development of the health sector for execution of the policy.- Provide support to HIV Focal Points in the various Ministries , Technical Working Groups and RHAs with a view to improving their effectiveness;- Coordinate the monitoring and evaluation of the HIV Policy in Jamaica.
National Sexual Health Authority (National Family Planning Board)	<ul style="list-style-type: none">- Promote public awareness and acceptance of the HIV Policy- Ensure sexual and reproductive health (SRH) is integrated into the national HIV response.- Guide the implementation, monitoring and periodic review of this policy.- Ensure the development of a national database of HIV and AIDS related policies and facilitate policy dissemination.- Support the development and periodic review of sector HIV and AIDS policies, strategies and action plans.



- Put in place mechanisms for the development and periodic review of a database of key stakeholders in the national response.
- Ensure the national response is evidence-based and uses the UNAIDS investment framework.
- Ensure the participation of all stakeholders, PLHIV and key population groups through dialogues, consultations and information dissemination.
- Collaborate with the NHP to mobilise the resources required to scale up the provision of HIV prevention services in the country.
- Implement activities to promote the human rights of PLHIV and key population groups
- Publish and disseminate guidelines for the implementation of a rights-based approach to HIV prevention, treatment, care and support
- Guide civil society and other organisations on the awareness of practices, behaviours, attitudes or cultures that undermine HIV prevention, treatment, care and support.
- Examine any law, policies and or strategies which are likely to negatively impact the HIV response and prevent individuals from claiming their human rights.
- Design SRH programmes including on family planning, gender and girl child

Regional Health Authorities

- Translate the HIV Policy into region-specific strategies and activities;
- Build capacity of staff in HIV programme planning and implementation;
- Monitor and evaluate regional programmes for their impact
- Commit adequate resources for implementation of HIV and related activities;
- Disaggregate data and information by sex, age and gender where applicable;
- Collaborate with the MoH, civil society, private sector and organisations of people living with HIV on HIV and related issues.

Ministry of Education

- Translate the HIV Policy into ministry-specific strategies and activities
- Integrate modes of transmission, prevention and control of HIV and AIDS and other sexually transmitted diseases into examinable subjects taught in public and private schools at primary and secondary levels.
- Provide primary prevention and comprehensive SRH knowledge and information to in-school youth.
- Provide HIV prevention information, education and life skills and sexual education in formal and non-formal education.
- Ensure that each teacher of an HIV and AIDS prevention and control course is properly trained, qualified and adequately resourced to teach the course.



- Develop and adopt appropriate HIV course content, scope and methodology at the Teachers' Colleges.
- Monitor and evaluate MoE programmes for their impact on the national response.
- Commit adequate resources for implementation of HIV-related activities;
- Collaborate with the MoH, civil society and the private sector on HIV and SRH matters.
-

Ministry of Youth

The MoY is mandated to lead the national HIV response among youth and youth organisations.

- Translate the HIV Policy into ministry-specific strategies and activities
- Target youth and youth organisations with information, education and HIV testing and counselling.
- Ensure that the youth have access to youth-friendly HIV prevention information and services to prevent the transmission of HIV and other STIs.
- Disseminate comprehensive SRH knowledge and information to all youth, with a particular focus on out-of-school youth and those in state care.
- Monitor and evaluate MoY programmes for their impact on the national response.
- Target key and vulnerable youth, especially MSM, youth with disabilities and youth living on the streets with HIV information and education.
- Commit adequate resources for implementation of HIV-related activities

Ministry of Finance and Planning

- Provide financial oversight of the national response.
- Ensure that grant and loan funds for the HIV response are given priority in the budget and warrant process.
- Ensure that growth and investment plans include HIV and related issues
- Ensure that HIV and AIDS, STI programmes are mainstreamed in the sector budget and ensure adequate and timely releases of government commitment towards implementation of the HIV Policy.
- The Planning Institute of Jamaica, a department of the MoFP facilitates planning and policy issues and supports public and other special consultations.
-

Ministry of Labour and Social Security (MLSS)

The MLSS is responsible for workplace and social protection issues.

- Set standards, develop guidelines, disseminate information and data and monitor HIV and work place issues;
- It will lead on HIV/AIDS workplace interventions including incorporating HIV/AIDS workplace issues into the Occupational Health and Safety Act



- Provide guidance to government and private sector organisations to adopt HIV/AIDS workplace policies and implement programmes.
 - Develop HIV interventions, strategies and programmes to mitigate the impact of HIV and AIDS, STIs on key populations, youth, the aged, women and children, the poor and PWDs.
 -
- Ministry of Tourism
- Promote HIV and AIDS workplace policy and prevention initiatives within the tourism sector.
 - Monitor and evaluate Ministry of Tourism programmes for their impact on the national response.
 - Commit adequate resources for implementation of HIV-related activities within the tourism sector
- Ministry of National Security (MNS)
- Translate the HIV Policy into ministry-specific strategies and activities
 - Conduct human rights and HIV training to all security personnel
 - Integrate HIV prevention information and education into the police staff training curriculum
 - Train police to address HIV-related stigma and discrimination and gender based violence
 - Monitor and evaluate MNS programmes for their impact on the national response.
 - Commit adequate resources for implementation of HIV-related activities
- Ministry of Justice
- Provide guidance in the review and amendment of legislation related to HIV and AIDS, STIs;
 - Prepare legislation on reproductive health, HIV and AIDS, STIs and other related matters based on approval from Cabinet
- Bureau of Gender Affairs (Office of the Prime Minister)
- Develop and implement strategies, policies and programmes that respect, protect and fulfil the human rights of women and girls in the context of HIV.
 - Mainstream HIV into gender-related strategies and interventions.
 - Develop and implement programmes and activities as regards gender-based violence and HIV.
 - Provide guidance for gender-sensitive and gender-responsive HIV and AIDS programmes and activities
- Parliament
- Provide legislation for new areas and the reform of existing laws to facilitate the implementation of this policy
 - Engage in policy dialogue geared at reducing discriminating and stigmatising provisions that affect PLHIV and key and vulnerable populations
 - Provide high-level advocacy in support of programmes by Government, NGOs and the private sector for key and vulnerable groups in their constituencies.



OTHER KEY STAKEHOLDERS

Civil Society Organisations

- Civil Society Organisations will partner with government to implement various aspects of the national response, ensure that government fulfils its role and responsibilities and be involved in sustained advocacy for the protection of the rights of all Jamaicans, in particular the rights of key populations and the vulnerable.
- Develop and implement SRH, HIV and AIDS prevention, treatment, care and support programmes and activities in line with the priorities of the National HIV/AIDS Strategic Plan 2012 – 2017 and the National Integrated Strategic Plan for SRH and HIV 2014 – 2019.
- Provide SRH, HIV and AIDS prevention, care and support services that are affordable and sustainable at the grassroots level;
- Participate in national co-ordination activities to minimise duplication
- Key CSOs in the response include: Jamaica AIDS Support for Life, ASHE, Children First, Jamaica Network of Seropositives, Hope World wide, EVE for Life, Jamaica Community of Positive Women, Children of Faith, Jamaica Forum for Lesbians All Sexuals and Gays (JFLAG) and the Carriibbean Vulnerable Communities Coalition.

Private Sector

- The Private Sector should locate HIV and AIDS issues within its corporate and operational agenda
- Establish and sustain HIV training and advocacy among management and employees of private sector companies
- Mobilise private sector financial and other resources for HIV and AIDS and SRH activities for the workforce and surrounding communities;
- Integrate SRH and HIV and AIDS into orientation sessions and training courses for private sector workers and managers
- Broaden corporate social responsibility initiatives and interventions to include HIV anti-stigma and discrimination programmes in the workplace.
- Ensure that essential products, supplies and services are accessible to both women and men, especially the poor;
-

Key Affected Populations

PLHIV, adolescents and youth, women and girls, street and working children, MSM, SW, persons with disabilities, homeless persons, persons who use drugs and prison inmates are important partners for interventions from the design phase to evaluation.

Churches and Faith based Organisations

- Provide care and support services including risk assessment
- Assist in dispelling myths about HIV and encouraging behaviour change



- Promoting accepting attitude and behaviour towards persons with HIV and AIDS and key populations.
- Integrate messages and information about prevention, care and support into their ongoing activities;
- Identify and serve as advocates for key populations and vulnerable groups, such as MSM, SW, homeless persons, drug users, PWDs, women and children living with HIV or affected by sexual violence
- Develop BCC/IEC messages and programmes that stress the importance of family and moral values in stopping the spread of HIV and AIDS.

Regional Partners

This includes Pan Caribbean Partnership Against HIV/AIDS, the Caribbean Regional Strategic Framework, the University of the West Indies, the Caribbean Broadcasting Media Partnership on HIV/AIDS, the Caribbean Coalition of National Programme Coordinators, and the Caribbean Network of Persons Living with HIV and AIDS.

International Development Partners

- Development partners will work in support of this HIV policy. National international development partners and organisations involved in HIV and AIDS interventions in the country shall align with the National HIV and AIDS Policy, National HIV and AIDS Strategic Framework and Action Plan and the National Development Plan – Vision 2030.
- Establish appropriate donor coordination mechanisms for ensuring responsiveness of development cooperation to the HIV Policy;

Media

- The media is important to advocacy and increased visibility for HIV/AIDS issues.
- Media entities should be part of the workplace and business sector response in institutionalising HIV and AIDS training and sensitisation for staff, management and target populations.
- The government should encourage the development of policies and codes of conduct for the media and the advertising industry in order to increase sensitivity to HIV and human rights issues and avoid reinforcing negative stereotypes or sensationalism over HIV-related issues in reporting and advertising.
- Training and education of media personnel should become an integral part of media practice.



10.3. Programmatic Coordination

All programmes in the national response should establish technical working groups (TWG) to provide leadership and guidance for programme planning, implementation and monitoring and evaluation.

Suggested TWGs include:

1. National HIV prevention TWG
2. National HIV Treatment TWG
3. National Enabling Environment and Human Rights TWG
4. National Monitoring and Evaluation TWG

Sub-thematic programmes shall provide leadership for the implementation of the relevant HIV programmes and all HIV programme coordination should be decentralised for both the biomedical and the non-biomedical and regional coordination structures.

10.4. Broad Implementation Strategies

- a. HIV and AIDS issues should be mainstreamed into all relevant policies, plans and programmes.
- b. Establish a specific focal point for HIV and AIDS in each MDA.
- c. Strengthen the role of the NFPB to advise the Government of Jamaica on SRH and HIV issues based on best practices, and coordinating the involvement of stakeholders and partners in the implementation of the national response.
- d. Ensure that resources for an integrated SRH/HIV response are allocated and managed to ensure an effective and efficient national response.



11. RESOURCE MOBILISATION AND MANAGEMENT

There is need for dedicated, on-going funding to support the HIV response in Jamaica. Funds for existing programmes as well as for the expansion of services are needed at all levels. Piecemeal project funding will not be sufficient to ensure a comprehensive national response. There is an urgent need to adopt the UNAIDS Investment Framework to guide funding decisions and priorities.

It is estimated that only 30% of the key populations are currently being reached for prevention services. Funding gap remains a major bottleneck in scaling up prevention efforts. The 2012 financial sustainability study of Jamaica's HIV Program clearly shows that preventing one HIV infection at a cost of less than J\$501,000 remains a good financial investment and reduces the financial costs of the national response to HIV and AIDS. In particular, the study points out that the costs incurred by new infections from MSM and sex workers are very high and effective prevention in the short-term will result in lower spending on treatment in the long-term.

High-level dialogue with the Ministry of Health, Ministry of Finance and PIOJ to determine required funding per year, anticipated shortfalls in funding and implications based on health burden created by HIV and AIDS is a recommended strategy.

Other key policy guidelines towards resource mobilisation include the following:

- a. The Government of Jamaica should continue to allocate a percentage of the national budget to the HIV response and ensure allocated expenditure is utilised.
- b. Government MDAs should mainstream HIV into their mandate and allocate a budget from their ministry budgets for HIV interventions.
- c. Key NGOs and other networks, institutions and communities should access funding from the Government and other local and international donors in line with the National Strategic Plan.
- d. The NFPB and the NHP should coordinate and facilitate the development of a resource mobilisation and management plan the national HIV response. This should be disseminated to key stakeholders in the response.
- e. The NFPB, NHP and the Planning Institute of Jamaica should coordinate resource mobilisation efforts in line with the National Strategic Plan and maintain a database of all HIV implementing and funding partners in order to monitor the flow of financial resources.
- f. The NFPB should encourage targeted funding of interventions for specific vulnerable populations based on the UNAIDS Investment Framework and evidence.
- g. All stakeholders should share information with the NFPB and NHP to avoid duplication in the allocation and use of available resources.
- h. All stakeholders should share information with NFPB and NHP on barriers to access and use in all intervention areas, which shall be analysed and systematically addressed.
- i. Stakeholders should conduct resource mobilisation for HIV activities and financial assistance received shall be reported to the Planning Institute of Jamaica, which is responsible for coordinating external assistance to Jamaica.
- j. More efficient use of resources to targeted interventions towards MSM and SW should be explored including: 1) strategies that can link in other SRH services thereby reducing the unit cost and strengthening the integration of HIV into SHR; 2) expanding the HIV/SRH Prevention model to other health conditions (non-communicable diseases).
- k. Invest in more prudent evaluations of the reach versus the spend of programmes on an ongoing basis using a pre-established Research Agenda
- l. Advocacy should be heightened for the implementation a private sector-led HIV and AIDS Fund to provide long-term sustainable funding for the national response.



12. MONITORING AND EVALUATION

Monitoring and evaluation (M&E) is essential to assess the impact of the national response and provide recommendations for future policies, strategies and interventions. Monitoring and Evaluation is a highly technical and specialized field that requires appropriate expertise. Reports are required from such experts to be able to assess progress and amend previous strategies and interventions if necessary.

The policy will enable the selection of the M&E team by the appropriate body and will facilitate its access to information, on-site observations and interaction with relevant groups and individuals.

The Government through the NFPB will coordinate and facilitate monitoring and evaluation of the national response to HIV. All HIV implementing partners shall report their activities to the national HIV M&E system.

Objective

To develop and sustain an M&E system for the effective coordination, management and dissemination of data on HIV and AIDS – incorporating indicators as set out in the national plans and the UNGASS Declaration or Commitment on HIV/AIDS.

Specific activities include:

1. Maintaining and strengthening passive and active surveillance for HIV/AIDS through HIV/AIDS/STI sentinel surveillance and periodic behavioural surveillance among specific groups.
2. Strengthening capacities to monitor and evaluate programmes including the development and review of indicators.
3. Establishing a national HIV and AIDS data management system with linkages to other national data collections systems.
4. Facilitating regular dissemination of M&E data to partners and the general public.
5. The National HIV and AIDS Policy shall be reviewed every five years, a process that could take place at the same time as the review of the National Strategic Plan and utilizing similar indicators defined by the Plan of Action. The goal and strategies will be reviewed to ensure relevance to the national HIV situation.
6. Establishing a clear mechanism to link the policy with the impetus by the Government of Jamaica towards resource based monitoring and evaluation.

12.1. Implementation Benchmarks

The following benchmarks should be used by all organisations/institutions including churches and workplaces in Jamaica:

1. HIV/AIDS policy and implementation plan of action
 - All organisations have at least designated a Focal Point on HIV with a working committee representing management and employees and a PLHIV.
 - All organisations have a policy framework – guidelines or a full policy such as the National HIV and AIDS Policy, the National HIV and AIDS Workplace Policy, a Sector Policy on HIV/AIDS or an adaptation.
 - All organisations monitor and evaluate the HIV/AIDS policy and programme implementation.
2. Human Rights Approach



- All formal and informal sector organisations report zero-tolerance for discrimination against PLHIV and key population groups and actively implement the principle of greater involvement of people with HIV in the workplace.
 - All formal and informal sector organisations promote the principles on which the National HIV Policy are based.
 - No individual is discriminated against on the basis of real or perceived HIV status.
3. Prevention and training
- All Jamaicans have access to a broad range of ‘effective, rights-based, and evidence-informed measures aimed at preventing HIV transmission’.^{52 53}
 - All Jamaicans have access to accurate information on HIV and AIDS. As such, HIV-related awareness campaigns are to be supported.
 - At least 47.5% of Jamaicans can name at least three ways to protect themselves from HIV by 2017⁵⁴.
 - All Jamaicans have access to training/learning opportunities on HIV prevention.
 - All Jamaicans have access to voluntary and confidential HIV Counselling and Testing (HCT) and referral for treatment services if tested positive.
 - Gender is mainstreamed into all HIV programmes and activities
 - HIV and other SRH commodities, including male and female condoms, lubricants and family planning are accessible and available to all with instructions for their use.
4. Treatment, Care and support
- All Jamaicans have the right to the highest attainable standard of physical and mental health and as such should be able to access a range of treatment, care and support options regardless of perceived or real HIV status or sexual orientation.
 - All PLHIV have access to equitable and sustainable antiretroviral treatment (ART).

⁵² [ABA ROLI HIV/AIDS Legal Assessment Tool,
http://www.americanbar.org/content/dam/aba/directories/roli/misc/aba_rol_i_hiv_aids_legal_assessment_tool_11_12_authcheckdam.pdf](http://www.americanbar.org/content/dam/aba/directories/roli/misc/aba_rol_i_hiv_aids_legal_assessment_tool_11_12_authcheckdam.pdf).

⁵³ UNDP, Jamaica. 2013. HIV and AIDS Legal Assessment Report for Jamaica

⁵⁴ National Target set by Jamaica Monitoring and Evaluation Framework 2017 - 2017



13. ANNEXES

TO BE UPDATED

Annex 1: References

ABA ROLI HIV/AIDS Legal Assessment Tool,

http://www.americanbar.org/content/dam/aba/directories/roli/misc/aba_rol_i_hiv_aids_legal_assessment_tool_11_12.authcheckdam.pdf.

Barrow, G., Hylton-Kong T., Rodriguez N., Yasuhiro Yamamura., & Figueroa J.P. (2013). "HIV-1 drug resistance in treatment-naive, chronically infected patients in Jamaica." *Antiviral Therapy*, June 6
doi: 10.3851/IMP2869.

Brown, A., Tureski K., Bailey, A., Rogers, S. J., Cushnie, A., & AbidemiAdelaja, A.P. (2012). *Layered Stigma among Health Facility and Social Services Staff towards Most-at-Risk Populations in Jamaica*. Washington, D.C.: C-Change Project, FHI 360.

Caribbean Public Health Agency (CARPHA). (2013). *End-of-Term Evaluation of the Jamaica National HIV and AIDS Strategic Plan 2007 – 2012*. Prevention and Enabling Environment and Human Rights Components.

Chan, J. (2013). *Legal Reforms, Social Change: HIV/AIDS, Human Rights and National Development in Jamaica*, UNDP.

Charter of Fundamental Rights and Freedoms (2011). Accessed at

<http://www.supremecourt.gov.jm/constitution>

Child Care and Protection. (2004). Accessed at

<http://www.moj.gov.jm/sites/default/files/laws/Child%20Care%20and%20Protection%20Act.pdf>

Child Pornography Act. (2009). Accessed at

http://www.japarliament.gov.jm/attachments/341_The%20Child%20Pornography%20Act.pdf

Christie, C.D.C., & Pierre, R.B. (2012). *Eliminating Vertically-transmitted HIV/AIDS while Improving Access to Treatment and Care for Women, Children and Adolescents in Jamaica*. University of the West Indies.

2013 Clinical Management of HIV Disease Guidelines for Medical Practitioners

Domestic Violence Act. (2004). Accessed at

http://www.moj.gov.jm/sites/default/files/laws/The%20Domestic%20Violence%20Act_0.pdf

Economic and Social Survey of Jamaica (2011),

<http://webstore.pioj.gov.jm/reportdetails.aspx?Docid=191>

Insurance Act, <http://www.moj.gov.jm/sites/default/files/laws/The%20Insurance%20Act.pdf>



Francis M, K. (2013). *Technical Needs Assessment Report to identify bottlenecks to implementation of Jamaica's National HIV Strategic Plan (2012 – 2017)*. Kingston, UNAIDS.

Ferguson, T.S. et al. *National health surveys and health policy: impact of the Jamaica health and lifestyle surveys and the reproductive health surveys*. West Indian Medical Journal, Mona, v. 61, n. 4, July 2012. Accessed at http://caribbean.scielo.org/scielo.php?script=sci_arttext&pid=S0043-31442012000400015&lng=en&nrm=iso. on May 15, 2015.

Hope Caribbean Company Limited. (2012). *2012 HIV/AIDS Knowledge, Attitudes and Behaviour Survey Jamaica*. Report of Findings from HIV/AIDS Knowledge, Attitudes and Behaviour Survey Jamaica 2012.

Joint United Nations Programme on HIV/AIDS (UNAIDS). (2014). *The Gap Report*. Geneva, Switzerland

Joint United Nations Programme on HIV/AIDS (UNAIDS) 2006. *International Guidelines on HIV/AIDS and Human Rights 2006 Consolidated Version*. Switzerland. Accessed at <http://www.ohchr.org/Documents/Publications/HIVAIDSGuidelinesen.pdf> on May 15, 2015.

Joint United Nations Programme on HIV/AIDS. (2014). *90-90-90 An ambitious treatment target to help end the AIDS epidemic*. Accessed at http://www.unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf on May 20, 2015.

Interagency Coalition on AIDS and Development. *HIV, Gender, Sexual and Reproductive Health Rights and the Post 2015 Development Agenda*. January 2015. Accessed at http://www.icad-cisd.com/pdf/Publications/Post2015_EN-FINAL.pdf on May 20, 2015

Medium-Term Framework 2012-2015. (2013). Vision 2030, [http://www.vision2030.gov.jm/Portals/0/MTF/MTF%202012-2015%20\(Final\).pdf](http://www.vision2030.gov.jm/Portals/0/MTF/MTF%202012-2015%20(Final).pdf)

Ministry of Health (Jamaica). (2005). *National HIV Policy*.

Ministry of Health, Jamaica. (2012). *Guidelines for HIV Case-based Surveillance*.

Ministry of Health, Jamaica. (2013). *Guidelines for the Clinical Management of HIV/AIDS*.

Ministry of Health (Jamaica). (2013). *Jamaica 2013 Mid-term Review Report: United Nations General Assembly Political Declaration on HIV/AIDS*.

Ministry of Health. National Family Planning Board. (2014). *Global AIDS Response Programme Report 2014: Jamaica Country Report*.

Ministry of Health. National HIV/STI Programme. (2012). *Jamaica – National AIDS Spending Assessment. An Assessment of HIV and AIDS Financing Flows and Expenditure*. Kingston, Jamaica: MOH.

Ministry of Health. (2012). *2012 Global AIDS Response Progress Report: Jamaica Country Report*. Kingston, Jamaica: MOH.

Revised National HIV Policy 2017, Jamaica



Mziray, E., Haacker, M., & Shiyan, C. (2012). *Assessing the Financial Sustainability of Jamaica's HIV Program*. Washington DC: World Bank.

2012 Modes of Transmission of HIV in Jamaica.

2012 National Commitments and Policies Instrument (NCPI),

<http://www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2012countries/Jamaica%20NCPI%202012.pdf>

National Policy for Gender Equality. (2012). Accessed at <http://www.jis.gov.jm/pdf/NPGE-JA-FINALwCover21311.pdf>

National Target set by Jamaica Monitoring and Evaluation Framework 2017 – 2017.

2011 National Survey of Attitudes and Perceptions of Jamaicans Towards Same Sex Relationships,

<http://www.aidsfreeworld.org/Our-Issues/Homophobia/~media/Files/Homophobia/NATIONAL%20SURVEY%20OF%20ATTITUDES%20AND%20PERCEPTIONS%20OF%20JAMAICANS%20TOWARDS%20SAME%20SEX%20RELATIONS%20HIPS.pdf>

2012 National Workplace Policy on HIV/AIDS,

<http://www.mlss.gov.jm/download/NationalWorkplacePolicyDraft.pdf>

National HIV/STI Programme. National Strategic Plan on HIV and AIDS 2012 – 2017

Offences Against the Person Act (1864),

http://www.vertic.org/media/National%20Legislation/Jamaica/JM_Offences_against_the_Person_Act.pdf

PANCAP CARICOM model anti-discrimination legislation.

PANCAP Regional Stigma and Discrimination Unit Newsletter Vol.1, Spotlight on stigma

<http://www.cvccoalition.org/downloads/Spotlight1.pdf>

Panos Caribbean. (2010). *Oral Testimonies of Jamaican Sex Workers*.

Panos Caribbean. (2012). *A Baseline Report on the Media's Treatment and Coverage of MSM Issues in Jamaica: August to November 2011*.

Planning Institute of Jamaica. (n.d). *Economic and Social Survey*.

Planning Institute of Jamaica. (n.d). *National Development Plan Vision 2030*.

Public Health Act, <http://www.moj.gov.jm/sites/default/files/laws/Public%20Health%20Act.pdf>

Reproductive Health Survey (2008),

<http://ghdx.healthmetricsandevaluation.org/series/reproductive-health-survey-rhs>



Reback, C.J., & Fletcher J.B. (2014). *HIV prevalence, substance use, and sexual risk behaviours among transgender women recruited through outreach*. Published in *AIDS Behaviour*. 2014 Jul. 18(7):1359-67. doi: 10.1007/s10461-013-0657-z.

Ruiz Román, Elena. *Assessing a Social Protection Framework for Vulnerable People Living with HIV in Jamaica*. UNDP, Jamaica.

Simms, G. P. (2013). *Gender Assessment of the National Response to HIV in Jamaica*.

Sexual Offences Act (2009),

http://www.japarliament.gov.jm/attachments/341_The%20Sexual%20Offences%20Act,%202009.pdf

The International Bank for Reconstruction and Development. (2007). *Planning and Managing for HIV/AIDS Results A Handbook*

Towns and Communities Act (1847, last amended in 1997),

<http://www.moj.gov.jm/sites/default/files/laws/Towns%20and%20Communities%20Act.pdf>

Trafficking in Persons (2007),

[http://www.cda.gov.jm/sites/default/files/content/Trafficking%20in%20Persons%20\(Prevention,%20Suppression%20and%20Punishment\)-1.pdf](http://www.cda.gov.jm/sites/default/files/content/Trafficking%20in%20Persons%20(Prevention,%20Suppression%20and%20Punishment)-1.pdf)

Tureski K., K. Anderson, O., Rogers, S., & Cushnie, A. (2012). *Cross-Generational Relationships: Perceived Norms and Practices in Jamaica*. Washington, DC: C-Change/ FHI 360.

UNDP, Jamaica. (2013). *HIV and AIDS Legal Assessment Report for Jamaica*.

UNDP, Jamaica. (2013). *Legal Reforms, Social Change: HIV/AIDS, Human Rights and National Development in Jamaica*.

University of the West Indies. (2012). *Surveys of PLACE Patrons, PLACE Workers, and Men Who have Sex with Men*. Mona: University of the West Indies, Mona, Jamaica.

University of the West Indies (UWI), Ministry of Health., U.S. Agency for International Development (USAID) & Measure Evaluation. (2012). *Surveys of PLACE Patrons, PLACE Workers, and Men Who Have Sex with Men Final Report*. Mona: University of the West Indies, Mona, Jamaica.

UNWomen. 2011. *Human Rights Issues Confronted by HIV-positive Women in Jamaica*.

World Health Organisation. (2001) *Guidelines for the Management of Sexually Transmitted Infections*. Accessed on May 20, 2015 at <http://apps.who.int/medicinedocs/en/d/Jh2942e/2.4.html>

World Health Organisation. (2014). *Fact Sheet: Post-exposure Prophylaxis to prevent HIV*. Accessed December 2, 2014 at <http://www.who.int/hiv/topics/prophylaxis/info/en/>

Weir, S., Figureoa, J., Byfield, L., Jones-Cooper, C., Hobbs, M.M., et.al. (2013). *High HIV Prevalence among Men Who Have Sex with Men in Jamaica is Associated with Social Vulnerability and*



Other Sexually Transmitted Infections. The West Indian medical Journal (Impact Factor: 0.28).
01/2013; 62(4):286-91.



Annex 2: Policies, Strategic Plans and Regulations related to HIV

Name	Date of Enactment or Establishment or Timeframe	Description	Comments
Legislation/Policies			
National HIV Policy	2005		
The Charter of Fundamental Rights and Freedoms	2011	Prohibits discrimination on the grounds of i) being male or female; ii) race, place of origin, social class, colour, religion or political opinions.	The Charter of Rights does not prohibit discrimination on the grounds of health status, HIV status, gender identity, sexual orientation, or disability.
The Gender Equality policy		Seeks to improve the participation of women in all sectors of the society, and facilitate greater coordination and sustainability in the gender-mainstreaming process in all sectors.	
The National HIV/AIDS Workplace Policy	2010	This was adopted by Parliament in 2010. The Policy, if enacted, would impose anti-discrimination obligations on employers. The Policy was revised based on ILO Recommendation 200 and recommendations from the Attorney General of Jamaica and resubmitted to the Human Resources Committee of the Cabinet.	It was approved as a White Paper in February 2013
The Public Health (Notifiable Diseases) Order		Seeks to have HIV classified as a Class 1 notifiable disease for reporting purposes only in 2012. This amendment is important as, if enacted; it will remove provisions that are currently discriminatory for PLHIV in the context of education and employment in the food and tourism industries	
Management of HIV/AIDS in Schools Policy	2004	This Policy outlines non-discrimination standards for students living with or affected by HIV. It also outlines the need for education to be provided to students on HIV and AIDS.	This Policy needs to be revised
Strategic Plans/Frameworks			
Jamaica National HIV Strategic Plan	2012-2017	This is the framework that guides the implementation of the national response to HIV and AIDS in Jamaica over five years. It outlines the strategic direction/focus around six Priority Areas: <ul style="list-style-type: none"> ▪ Enabling Environment and Human Rights ▪ Prevention ▪ Treatment Care and Support ▪ Monitoring and Evaluation ▪ Governance and Empowerment and ▪ Sustainability The NSP emphasises leadership development and governance in order to facilitate the integration of HIV and AIDS into the development programmes of government and civil society institutions as well as the private sector.	This is the third NHP following the implementation of NSP 2002-2006 and 2007-2012
Draft Framework for HIV/AIDS	Strategic for 2009	This Framework provides the strategic guidance for managing HIV in Jamaica's prisons. It outlines strategies for prevention, testing and treatment for the incarcerated populations.	



Name	Date of Enactment or Establishment or Timeframe	Description	Comments
Incarcerated Populations in Jamaica			
Plan of Action for Orphans and Other Children Made Vulnerable by HIV/AIDS (2003)		This plan outlines strategies for assisting children impacted by HIV and AIDS, via social programmes, public education and coordination at the governmental level.	The Plan of Action is dated and requires revision
Current bills, amendments, and policy drafts are before the Jamaican			
Occupational Safety and Health Act		This Act ensures adherence to and compliance with stipulated protocols regarding the creation of conducive workplace environments that will safeguard employees' welfare, while enhancing productivity.	When passed, this law will give legislative effect to the National HIV/AIDS Workplace Policy. It will inter alia require private and public sector entities to adopt and implement polices within the workplace to address HIV-related discrimination.
Draft Policy Procedure Manual on Life Threatening Illnesses (LTI) in the Workplace (Ministry of Labour and Social Security).			This draft includes persons living with HIV and AIDS. The policy attempts to provide practical guidelines for dealing effectively with LTIs among employees including HIV.
Draft National Policy and Plan of Action on International Migration and Development (Planning Institute of Jamaica)		Responds to key global development challenges and opportunities associated with migration. Among these challenges is HIV and AIDS.	
Public Health Act	February 21, 1985	Promoting the public health and for preventing the spread of communicable and epidemic diseases.	
Child Care and Protection Act	March 26, 2004	Ensure care and protection of children and young persons and for connected matters.	
Employment Termination and Redundancy (Payment) Act	December 9, 1974	Employers must provide for the notice required to be given for the termination of contracts of employment, for the right of certain employees to certain facilities for returning to their homes on the termination of their contracts of employment, for the making by employers of payments to employees dismissed by reason of redundancy, and for purposes incidental to or connected with the matters aforesaid	
National Insurance Act and the Mortgage Insurance Act	June 15, 1960	Act to empower the Development Finance Corporation to issue insurance policies in respect of loans secured by mortgages of dwelling houses and for matters connected therewith or incidental thereto	
Offences Against the Person Act	January 1, 1864 (2010)	The crime that is committed is written along with its punishment.	
Education Act	December 16, 1965	Ensures the provision of a coordinated system of public education	

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Name	Date of Enactment or Establishment or Timeframe	Description	Comments
Immigration Restriction (Commonwealth Citizen Act)	December 17, 1945	Impose restriction on commonwealth persons	
Aliens Act	February 28, 1946	This Act is to impose restrictions on the landing of aliens and to provide for the supervision and deportation of aliens and for other purposes connected immigration	
Amendment to the Corrections Act	December 2, 1985		
National HIV/AIDS Control Authority (Policy)	March 2011	The purpose of the policy is to facilitate the development of a working environment that protects the rights of workers infected and/or affected by the epidemic by: 1. Developing a framework for action in the workplace. 2. Highlighting the rights and responsibilities of workers. 3. Articulating the usefulness of education, training, improved awareness; counselling, care and support in prevention, treatment and care efforts.	
Regulations under the Public Health Act as it relates to sex workers			
Pension Act	December 7, 1964	This Act is to provide for the payment of certain pensions, gratuities and other allowances	
National Family Planning Act	August 14, 1970		
Legal Aid Act	May 1, 2000	An act to make provision for the establishment and operation of a coordinated legal aid system in Jamaica, to establish a Legal Aid Council to administer legal aid and to provide for matters connected therewith or incidental thereto	



Annex 3: ILO Code of Practice on HIV/AIDS and the World of Work⁵⁵

1. Recognition of HIV/AIDS as a workplace issue

HIV/AIDS is a workplace issue, and should be treated like any other serious illness/condition in the workplace. This is necessary not only because it affects the workforce, but also because the workplace, being part of the local community, has a role to play in the wider struggle to limit the spread and effects of the epidemic.

2. Non-discrimination

In the spirit of decent work and respect for the human rights and dignity of persons infected or affected by HIV/AIDS, there should be no discrimination against workers on the basis of real or perceived HIV status. Discrimination and stigmatization of people living with HIV/AIDS inhibits efforts aimed at promoting HIV/AIDS prevention.

3. Gender equality

The gender dimensions of HIV/AIDS should be recognized. Women are more likely to become infected and are more often adversely affected by the HIV/AIDS epidemic than men due to biological, socio-cultural and economic reasons. The greater the gender discrimination in societies and the lower the position of women, the more negatively they are affected by HIV. Therefore, more equal gender relations and the empowerment of women are vital to successfully prevent the spread of HIV infection and enable women to cope with HIV/AIDS.

4. Healthy work environment

The work environment should be healthy and safe, so far as is practicable, for all concerned parties, in order to prevent transmission of HIV, in accordance with the provisions of the Occupational Safety and Health Convention, 1981 (No. 155). A healthy work environment facilitates optimal physical and mental health in relation to work and adaptation of work to the capabilities of workers in light of their state of physical and mental health.

5. Social dialogue

The successful implementation of an HIV/AIDS policy and programme requires cooperation and trust between employers, workers and their representatives and government, where appropriate, with the active involvement of workers infected and affected by HIV/AIDS.

6. Screening for purposes of exclusion from employment or work processes

HIV/AIDS screening should not be required of job applicants or persons in employment.

⁵⁵ International Labour Office. 2001. An ILO code of practice on HIV/AIDS and the world of work



7. Confidentiality

There is no justification for asking job applicants or workers to disclose HIV-related personal information. Nor should co-workers be obliged to reveal such personal information about fellow workers. Access to personal data relating to a worker's HIV status should be bound by the rules of confidentiality consistent with the ILO's code of practice on the protection of workers' personal data, 1997.

8. Continuation of employment relationship

HIV infection is not a cause for termination of employment. As with many other conditions, persons with HIV-related illnesses should be able to work for as long as medically fit in available, appropriate work.

9. Prevention

HIV infection is preventable. Prevention of all means of transmission can be achieved through a variety of strategies which are appropriately targeted to national conditions and which are culturally sensitive. Prevention can be furthered through changes in behaviour, knowledge, treatment and the creation of a non-discriminatory environment. The social partners are in a unique position to promote prevention efforts particularly in relation to changing attitudes and behaviours through the provision of information and education, and in addressing socio-economic factors.

10. Care and support

Solidarity, care and support should guide the response to HIV/AIDS in the world of work. All workers, including workers with HIV, are entitled to affordable health services. There should be no discrimination against them and their dependants in access to and receipt of benefits from statutory social security programmes and occupational schemes.



Annex 4

GLOSSARY OF TERMS

acute HIV infection	This is the early stage of HIV infection that extends approximately 2 to 4 weeks from initial infection until the body produces enough HIV antibodies to be detected by an HIV antibody test. Because the virus is replicating rapidly, HIV is highly infectious during this stage of infection.
acute retroviral syndrome	Flu-like symptoms of acute HIV infection that may appear approximately 2 to 4 weeks after infection. Symptoms such as fever, headache, fatigue, and swollen lymph nodes can last from a few days to 4 weeks, and then subside. During the acute stage of HIV infection, many, but not all, people will have symptoms of acute retroviral syndrome.
adherence	Taking medications exactly as prescribed. Poor adherence to an HIV treatment regimen increases the risk for developing drug-resistant HIV and virologic failure.
acquired immunodeficiency syndrome (AIDS)	Acquired Immunodeficiency Syndrome (AIDS) is a disease of the immune system due to infection with HIV. HIV destroys the CD4 T lymphocytes (CD4 cells) of the immune system, leaving the body vulnerable to life-threatening infections and cancers. Acquired immunodeficiency syndrome (AIDS) is the most advanced stage of HIV infection.
affected person	A person whose life is changed in any way by HIV and AIDS, due to the broad impact of the epidemic.
antiretroviral (ARV)	A drug that is the combination of at least three antiretroviral (ARV) drugs to maximally suppress the HIV virus and stop the progression of HIV disease or replicating. Huge reductions have been seen in rates of death and suffering when use is made of a potent ARV regimen, particularly in early stages of the disease. Antiretroviral Therapy (ART) is sometimes used in place of ARV.
antiretroviral therapy (ART)	The recommended treatment for HIV infection. Antiretroviral therapy (ART) involves using a combination of three or more antiretroviral (ARV) drugs from at least two different HIV drug classes to prevent HIV from replicating.
behaviour change	Behaviour change is usually defined as the adoption and maintenance of healthy behaviours.
behaviour change communication (BCC)	Behaviour change communication promotes tailored messages, personal risk assessment, greater dialogue, and an increased sense of ownership. BCC makes use of information, education and communication materials where communication is developed through an interactive process, with its messages and approaches using a mix of communication channels in order to encourage and sustain positive, healthy behaviours.
cisgender	A person whose gender identity matches their sex assigned at birth, and who therefore, unlike transgender people, experiences no gender incongruence.



comprehensive knowledge		Comprehensive knowledge of HIV/AIDS is knowing that both condom use and limiting sex partners to one uninfected partner are HIV prevention methods. This also entails being aware that a healthy-looking person can have HIV, and rejecting the two most common local misconceptions; that HIV/AIDS can be transmitted through mosquito bites and by sharing food.
concurrent partnerships	sexual	Persons who have concurrent sexual partnerships are those who report at least two partners for which first sex was reported six months or longer ago, and the most recent sex is reported as less than or equal to six months ago.
disclosure		Disclosure means telling someone that you are living with HIV (HIV+). Sharing your HIV status can help with the stresses of living with HIV.
discrimination		In this context of the policy, any distinction, exclusion, or preference made on the basis of HIV status, perceived HIV status, sexual orientation, age and gender. Discrimination consists of actions or omissions that are derived from stigma and directed towards those individuals who are stigmatised. Discrimination is action, which has the effect of nullifying or impairing equality of opportunity or treatment, in employment or occupation, in accordance with the definition and principles of the ILO Discrimination (Employment and Occupation) Convention, 1958 (no. 111).
enabling environment		There are different kinds of enabling environments in the context of HIV. An enabling legal environment is one in which laws and policies against discrimination on the basis of HIV status, risk behaviour, occupation, and gender are in place and are monitored and enforced. An enabling social environment is one in which social norms support healthy behaviour choices.
evidence-based programing		In the context of research, treatment, and prevention, evidence usually refers to qualitative and/or quantitative results that have been published in a peer-reviewed journal.
faith-based organisation		Faith-based organisation' is the term is used to refer to church, synagogue, mosque, or religious organisation.
gender		All attributes associated with women and men, boys and girls, that are socially and culturally ascribed and that vary from one society to another and over time.
gender equality		Gender equality, or equality between men and women, entails the concept that all human beings, both men and women, are free to develop their personal abilities and make choices without the limitations set by stereotypes, rigid gender roles, and prejudices. Gender equality means that the different behaviours, aspirations, and needs of women and men are considered, valued, and favoured equally. It signifies that there is no discrimination on the grounds of a person's gender in the allocation of resources or benefits, or in access to services. Gender equality may be measured in terms of whether there is equality of opportunity or equality of results.
gender equity		Gender equity is fairness and justice in the distribution of resources, benefits, and responsibilities between men and women, girls and boys in all spheres of life.



gender expression	The expression of one's gender identity, often through appearance and mode of dress, and also sometimes through behaviour and interests. Gender expression is often influenced by gender stereotypes.
gender identity	The personal experience of oneself as a boy or man, girl or woman, as a mix of the two, as neither, or as a gender beyond man or woman. Some individuals (particularly in cultures which accept the idea of genders beyond man and woman) identify as members of "third genders" or use indigenous gender labels.
gender-responsive programming	Gender-responsive programming refers to the ability of policies, programmes, or training modules to take into account that both women and men as actors within a society, are constrained in different and often unequal ways and that consequently they may have differing and sometimes conflicting perceptions, needs, interests, and priorities.
gender roles	These are the socially constructed and defined responsibilities assigned to males and females for example, child rearing is considered a female gender role. Gender roles are not universal and differ in different places and from time to time. They are also changeable and interchangeable.
gender sensitive	Gender sensitivity, is being conscious of the different situations and needs of women and men, throughout the decision-making process. It entails the ability to recognize the differences in perception and interests between males and females arising from their different social position and different gender roles.
Global Fund to Fight AIDS, Tuberculosis and Malaria	The Global Fund to Fight AIDS, Tuberculosis and Malaria, established in 2001, is an independent public/private partnership. The purpose of the Global Fund is to attract, manage, and disburse additional resources to make a sustainable and significant contribution to mitigate the impact caused by HIV, tuberculosis, and malaria in countries in need, while contributing to poverty reduction as part of the Millennium Development Goals.
harm reduction	This refers to policies, programmes, and approaches that seek to reduce the harmful health, social, and economic consequences associated with the use of psychoactive substances. For example, people who inject drugs are vulnerable to blood-borne infections such as HIV if they use non-sterile injecting equipment. Therefore, ensuring adequate supplies of sterile needles and syringes helps to reduce the risk of blood-borne infections. Harm reduction is a comprehensive package of evidence-informed programming for people who use drugs.
HIV testing and counselling	A process through which an individual receives information about HIV transmission and prevention, information about HIV tests and the meaning of tests results, HIV prevention counseling to reduce their risk for transmitting or acquiring HIV, and is provided testing to detect the presence of HIV antibodies. This is the process by which an individual undergoes counselling, enabling him or her to make an informed choice about being tested for HIV. Testing without counselling has little impact on behaviour and is a significant lost opportunity to assist people to avoid acquiring or transmitting infection.
homeless drug users	Homeless drug users are persons living on the street, in a shelter, in a single room occupancy hotel, or in a car or temporarily staying with friends or relatives who misuses drugs tended to use an illicit drug that provided a similar effect as the



prescription drug they were already misusing. Intravenous drug use and needle-sharing can transmit HIV; less known is the role that drug abuse in general plays. A person under the influence of certain drugs is more likely to engage in risky behaviours such as having unsafe sex with an infected partner.

human rights	Human rights are rights inherent to all human beings, whatever the nationality and place of residence, sex, national or ethnic origin, colour, religion, language, or any other status. All are equally entitled to our human rights without discrimination. These rights are all interrelated, interdependent and indivisible.
key population	The term refers to those who are most likely to be exposed to HIV or to transmit it. Their engagement is critical to a successful HIV response i.e. they are key to the epidemic and key to the response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender persons, people who inject drugs, sex workers and their clients, and seronegative partners in serodiscordant couples are at higher risk of HIV exposure to HIV than other people.
life threatening illnesses	An illness or situation that makes it possible that the person affected will die.
linkages	This describe synergies in policy, programmes, services, and advocacy between the field of sexual and reproductive health and the field of HIV prevention and treatment. It refers to a broad approach based on human rights, of which service integration is a subset.
linkage and retention in care	Improving the health of persons with HIV and reducing the number of new HIV infections will depend on increasing access to HIV medical care and eliminating disparities in the quality of care received. To advance these goals, clinicians and community-based HIV prevention providers can support persons diagnosed with HIV infection to fully engage in HIV medical care.
Millennium Development Goals (MDGs)	Eight goals were agreed at the Millennium Summit in September 2000. Goal 6 refers specifically to halting and reversing HIV. Lack of progress across other MDGs may seriously curtail progress in tackling HIV and, conversely, success in attaining other MDGs is being hampered by the HIV epidemic. The concept of AIDS and MDGs implies sharing lessons and building stronger links between the global HIV response and broader health and development agendas.
men who have sex with men (MSM)	The term describes males who have sex with males, regardless of whether or not they have sex with women or have a personal or social gay or bisexual identity. This concept is useful because it also includes men who self-identify as heterosexual but have sex with other men.
modes of transmission (MOT)	MoT refers to an epidemiological model developed by UNAIDS to help countries calculate HIV incidence by mode of transmission in the short term. The model incorporates biological and behavioural inputs, such as HIV and sexually transmitted infection prevalence, risk behaviours, and transmission probabilities. This process is sometimes referred to as 'Know your Epidemic' and 'Know your Response' or 'Tailor your Response'.



multiple sexual partnerships	A relationships between men and women who have more than one sexual relationships at the same time. These relationship can be long or short term. Some persons have multiple sex partners for pleasure while others do this to increase social status. When people engage in unprotected sex with many different partners they increase their chances of becoming infected with HIV.
opportunistic infection (OI)	Opportunistic infections are illnesses caused by various organisms, many of which usually do not cause disease in persons with healthy immune systems. Persons living with advanced HIV infection may have opportunistic infections of the lungs, brain, eyes, and other organs. Tuberculosis is the leading HIV-associated opportunistic infection in developing countries.
orphans and vulnerable children (OVC)	Children who have lost either one or both parents to HIV.
outreach	HIV/AIDS interventions generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in neighbourhoods or other areas where they typically congregate. Outreach may include distribution of condoms and educational materials as well as HIV testing. A major purpose of outreach activities is to encourage those at high risk to learn their HIV status and to test them for HIV or to refer them for testing.
people living with HIV	The term encompasses family members and dependents who may be involved in caregiving or otherwise affected by the HIV-positive status of a person living with HIV.
post exposure prophylaxis	Post-exposure prophylaxis refers to antiretroviral medicines that are taken after exposure or possible exposure to HIV. The exposure may be occupational, as in a needle stick injury, or non-occupational, as in unprotected sex with a partner with HIV infection.
prevalence	The total number of cases of a disease in a given population at a particular point in time. HIV/AIDS prevalence refers to persons living with HIV, regardless of time of infection or diagnosis date. Prevalence does not give an indication of how long a person has had a disease and cannot be used to calculate rates of disease. It can provide an estimate of risk that an individual will have a disease at a point in time.
prevention of mother to child transmission	This refers to a 4-prong strategy for stopping new HIV infections in children and keeping mothers alive and families healthy. The four prongs are: halving HIV incidence in women (Prong 1), reducing unmet need for family planning (Prong 2), providing antiretroviral prophylaxis to prevent HIV transmission during pregnancy, labour and delivery, and breastfeeding (Prong 3), and providing care, treatment and support for mothers and their families (Prong 4). PMTCT is often mistakenly used to refer to only Prong 3— the provision of antiretroviral prophylaxis.
prevention with positives	This refers to a set of actions that help people living with HIV (PLHIV) to live longer and healthier lives. Its scope includes actions that empower them to: “Protect their own sexual and reproductive health – avoid sexually transmitted infections (STI); delay HIV disease progression; and promote shared responsibility to avoid onwards transmission of HIV. The aim of prevention for people living with HIV is to ensure



their meaningful contribution and participation in halting the growing rate of new infections.

Psychosocial Support The non-physical care meant to address challenges of isolation, depression, anxiety, other psychiatric impairment, and serious interpersonal problems as a result of HIV and AIDS. The purpose of psychosocial support is to ensure that quality of life and motivation to live are effectively optimised.

referral A process by which immediate client needs for prevention, care, and supportive services are assessed and prioritized and clients are provided with assistance in identifying and accessing services (such as, setting up appointments and providing transportation). Referral does not include ongoing support or case management. There should be a strong working relationship (preferably a written agreement) with other providers and agencies that might be able to provide needed services.

regional health authority A Regional Health Authority (RHA) is a regional governance structure set up by the provincial government to be responsible for the delivery and administration of health services in a specific geographical area.

risk factors Risk is defined as the probability that a person may acquire HIV infection. Certain behaviours create, enhance (increase) and perpetuate risk which are known as factors. Some examples include unprotected sex with a partner whose HIV status is unknown; multiple unprotected sexual partnerships; injecting drug use with contaminated needles and syringes.

Sex and Gender The term 'sex' refers to biologically determined differences, while the term 'gender' refers to differences in social roles and relations between males and females. Gender roles are learned through socialization and vary widely within and between cultures. Gender roles are affected by age, class, race, ethnicity, and religion, and by the geographical, economic, and political environment.

sex workers Sex workers include consenting female, male, and transgender adults and young people over the age of 18 who receive money or goods in exchange for sexual services, either regularly or occasionally. Acceptable alternative formulations for the term 'sex worker' are 'women/men/people who sell sex'. Clients of sex workers may be called 'men/ women/people who buy sex'. The term 'commercial sex worker' is not used because it says the same thing twice in different words. Children selling sex under the age of 18 are considered to be victims of commercial sexual exploitation (see under 'prostitution'), unless otherwise determined.

sexual abuse Abuse of a person targeting his or her sexual organs, e.g., rape, touching the person's private parts, or inserting objects into the person's private parts.

sexual orientation Sexual orientation refers to each person's profound emotional and sexual attraction to and intimate and sexual relations with, individuals of a different, the same, or both sexes.

sexual and reproductive health Sexual and reproductive health (SRH) is an essential component of the universal right to the highest attainable standard of physical and mental health. services for family planning; infertility services; maternal and new-born health services;



prevention of unsafe abortion and post-abortion care; prevention of mother-to-child transmission of HIV; diagnosis and treatment of sexually transmitted infections, including HIV infection, reproductive tract infections, cervical cancer, and other gynaecological morbidities; promotion of sexual health, including sexuality counselling; and prevention and management of gender-based violence.

sexually transmitted infections (STIs)	Diseases transmitted through sexual intercourse and which include, among others, syphilis, chancroid, chlamydia, and gonorrhoea.
stigma	A dynamic process of devaluation that significantly discredits an individual in the eyes of others.
sustainable development goals (SDGs)	These are a new, universal set of goals, targets and indicators that UN member states will be expected to use to frame their agendas and political policies over the next 15 years.
“Three Ones” principle	<p>The ‘Three Ones Principles’ for concerted action at country level have been recognized by international organizations and national governments as the guiding principles to ensure effective coordination of national responses to HIV and AIDS. The principles are:</p> <ul style="list-style-type: none">• One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners;• One National HIV/AIDS Coordinating Authority, with a broad-based multi-sectorial mandate;• One agreed HIV/AIDS country-level Monitoring and Evaluation (M&E) System. <p>The Three Ones principles aim to mobilize national leadership and ownership, to promote coordination of the efforts at the national level in an inclusive and transparent manner, and to achieve the most effective and efficient use of HIV and AIDS related resources (i.e. avoid duplication and fragmentation of resources) through an accelerated process of national coordination to achieve measurable results.</p>
treatment as prevention	Treatment as prevention (TasP) refers to HIV prevention methods that use antiretroviral treatment (ART) to decrease the risk of HIV transmission. ART reduces the HIV viral load in the blood, semen, vaginal fluid and rectal fluid to very low levels ('undetectable'), reducing an individual's risk of HIV transmission. Treatment as prevention has been utilized to prevent mother to child transmission (MTCT).
universal access	Universal access implies maximal coverage of HIV prevention, treatment, care, and support services for those who require them. Basic principles for scaling up towards universal access are that services must be equitable, accessible, affordable, comprehensive, and sustainable over the long term. Because different settings often have distinctly different needs, targets for universal access are set nationally.
universal precautions	A simple standard of infection control practice used to minimise the risk of blood-borne pathogens.



viral load	The amount of HIV in a sample of blood. Viral load (VL) is reported as the number of HIV RNA copies per millilitre of blood. An important goal of antiretroviral therapy (ART) is to suppress a person's VL to an undetectable level—a level too low for the virus to be detected by a VL test.
voluntary counselling and testing (VCT)	VCT is voluntary HIV testing that involves a process of pre- and post-test counselling, which helps people to know their sero-status and make informed decisions.
vulnerable populations	Vulnerable populations are defined as those at greater risk for poor health status and health care access. This include the elderly, the homeless, those PLHIV, and those with other chronic health conditions, including severe mental illness. The vulnerability of these individuals is enhanced by race, ethnicity, age, sex, and factors such as income, insurance coverage (or lack thereof), and absence of a usual source of care.
women's empowerment	The process of enhancing women's capacity to take charge of their own development. The process involves enabling women to make their choices, have a say in decisions that affect them, ability to initiate actions for development, change in attitudes, and increased consciousness of equal access to and control of resources and services in order to take charge of their opportunities.