

JAMAICA
National Integrated
Strategic Plan for Sexual
and Reproductive
Health & HIV
2014 – 2019

PREFACE

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANCA	Anti-neutrophil cytoplasmic antibodies
ART	Antiretroviral Treatment
ARV	Antiretroviral
BCC	Behaviour Change Communication
CARPHA	Caribbean Public Health Agency
CBO	Community Based Organisation
CDA	Child Development Agency
CDC	Centres for Disease Control and Prevention
CD ₄	Cluster designation
CHS	Casual Heterosexual Sex
CIDA	Canadian International Development Agency
CNCD	National Council for Combating Discrimination
CSR	Corporate Social Responsibility
CSW	Commercial Sex Worker
CPR	Contraceptive Prevalence Rate
CSOs	Civil Service Organization
DFATD	Department for Trade and Development
DFID	Department for International Development
EFF	Extended Fund Facility
eMTCT	Elimination of Mother to Child Transmission
ERTU	Epidemiology and Research Training Unit
FBO	Faith Based Organisation
FDA	Food and Drug Administration
FP	Family Planning
FSW	Female Sex Worker
GARPR	Global AIDS Response Progress Reporting
GBV	Gender Based Violence
GIPA	Greater Involvement of People Living with HIV and AIDS
GOJ	Government of Jamaica
HAART	Highly Active Antiretroviral Therapy
HCW	Health Care Worker
HEART	Human Employment and Resource Training Agency
HIV	Human Immuno-deficiency Virus
HIV/STI/MOH	HIV/STI Programme in the Ministry of Health
HPV	Human papillomavirus
HTC	HIV Testing and Counselling
IBRD	International Bank for Reconstruction and Development
ICO	Institut Català d'Oncologia
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication

IDB	Inter-American Development Bank
IDPs	International Development Partners
IDU	Injecting Drug Use
ILO	International Labour Organization
IMF	International Monetary Fund
IOM	International Organisation on Migration
IPV	Intimate Partner Violence
IUCD	Intrauterine Contraceptive Device
IUD	Intra Uterine Device
JHTA	Jamaica Hotel and Tourism Association
KAPB	Knowledge, Attitudes, Practices and Behaviour
LGBT	Lesbian, Gay, Bisexual, and Transgender
LTIs	Life Threatening Illnesses
MDAs	Ministries, Departments and Agencies
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MCSR	Monthly Clinic Summary Report
MERG	UNAIDS M&E Reference Group
MLSS	Ministry of Labour and Social Security
MNH	Maternal New-born Health
MOH	Ministry of Health
MOE	Ministry of Education
MOFP	Ministry of Finance and Planning
MOJ	Ministry of Justice
MOT	Modes of Transmission
MOY	Ministry of Youth
MOYC	Ministry of Youth and Culture
MSM	Men who have Sex with Men
NHDRSS	National HIV-Related Discrimination Reporting and Redress System
MTF	Medium Term Socio-Economic Policy Framework
NAC	National AIDS Committee
NAP	National AIDS Programme
NTA	National Training Agency
NCDA	National Council and Drug Abuse
NFPB	National Family Planning Board
NGO	Non-Government Organisation
NHP	National HIV/STI Programme
NISP	National Integrated Strategic Plan for Sexual and Reproductive Health and HIV
NSP	National Strategic Plan
OCR	Office of the Children’s Registry
OCA	Office of the Children’s Advocate
OI	Opportunistic Infection

OTC	Over-the-counter
PAC	Parish AIDS Committee
PANCAP	Pan Caribbean Partnership against HIV/AIDS
PAHO	Pan American Health Organization
PATH	Programme for Advancement through Health and Education
PHDP	Positive Health Dignity and Prevention
PEFPAR	President’s Emergency Plan for AIDS Relief
PeP	Post Exposure Prophylaxis
PIFP	Provider-initiated Family Planning
PIOJ	Planning Institute of Jamaica
PITC	Provider-Initiated Counselling and Testing
PLACE	Priorities for Local Control AIDS Efforts
PLHIV	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PNC	Post-natal Care
POC	Point of Care
PWDs	Persons with Disabilities
RHAs	Regional Health Authorities
RHS	Reproductive Health Surveys
RTI	Reverse-transcriptase Inhibitors
SALISES	Sir Arthur Lewis Institute of Social and Economic Studies
S&D	Stigma and Discrimination
SH	Sexual Health
SHA	Sexual Health Agency
SRH	Sexual and Reproductive Health
SOPs	Standard Operating Procedures
STATIN	Statistical Institute of Jamaica
STI	Sexually Transmitted Infection
STD	Sexually Transmitted Disease
SWOT	Strength Weaknesses Opportunities and Threats
TG	Transgender
UNDP	United Nations Development Programme
UNAIDS	United Nations Programme on HIV/AIDS
UNICEF	United Nations Children’s Fund
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UWI	University of the West Indies
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

EXECUTIVE SUMMARY

The Jamaica National Integrated Strategic Plan for Sexual and Reproductive Health and HIV (NISP) 2014-2019 was developed to direct the implementation of an integrated approach to Sexual and Reproductive Health (SRH) and HIV planning and programming in Jamaica over the next five years.

The NISP 2014 – 2019 draws on the successes and lessons learnt from the earlier plans of the National HIV/STI Programme (NHP) and the National Family Planning Board (NFPB), and broadens and deepens national efforts to address key sexual and reproductive health concerns, including the prevention and alleviation of the impact of HIV, in a coordinated manner. Its execution over the next five years will play an important role in Jamaica's National Development Plan – Vision 2030 Jamaica, into which HIV and Population and Development goals and strategies have been integrated.

Sexual and reproductive health and rights – as part of inalienable human rights – will underpin the National Integrated Strategic Plan. The achievement of universal access to sexual and reproductive health services, the realization of reproductive rights, and a reduction in maternal mortality through an enhanced focus on family planning and maternal health will be critical. Reaching these goals would bring enormous benefits to the people of Jamaica by accelerating progress on the International Conference on

Population and Development (ICPD) agenda.

The plan provides a blue print for achieving the vision of an integrated programme while supporting the achievement of the Millennium Development Goals (MDGs), the Sustainable Development Goals (SDGs) and the Fast-Track strategy to end the AIDS epidemic by 2030.

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. The integration of elements of the National HIV/STI Programme (NHP) into the National Family Planning Board (NFPB) to form the Sexual Health Agency represents a step for Jamaica towards realising the Three Ones principles (of One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners; One National AIDS Coordinating Authority, with a broad based multi-sector mandate; One agreed country level Monitoring and Evaluation System).

The integration gives effect to one of the key strategies outlined in Vision 2030- Jamaica's National Development Plan, to "expand and improve integration of family planning, maternal and child health, sexual and reproductive health and HIV into primary health care." The plan also responds to the policy recommendations from the International Conference on Population and Development (ICPD) Programme of Action (1994) and the Glion Call to Action on Family Planning and HIV/AIDS in Women and Children (2004) among other international commitments.

The linkages between HIV and SRH are evident and the importance of linking both these areas in policy and programme development and service delivery is widely recognised.

There is significant evidence of the benefits of the integrated SRH and HIV response.¹ Some of these include:

- Improved quality of care
- Enhanced programme effectiveness and efficiency
- Better utilization of scarce human resources for health
- Decreased duplication of efforts and competition for resources
- Mutually reinforcing complementarities in legal and policy frameworks
- Improved access to and uptake of key HIV and SRH services
- Better access of people living with HIV (PLHIV) to SRH services tailored to their needs
- Reduction in HIV-related stigma and discrimination
- Improved coverage of underserved/vulnerable/key populations
- Greater support for dual method protection

In Jamaica HIV care and treatment efforts are already formally and informally linked to various SRH care and treatment efforts including: antenatal care via the Prevention of Mother to Child Transmission (PMTCT) programme work; family planning via the provision of condoms and the promotion of dual method contraception; to STI care and treatment via identification of increased risk of HIV infection among STI clinic attendees and associated testing and treatment responses/initiatives and components of Positive Health, Dignity, and Prevention (PHDP) programmes linked to promotion of condom use and dual method contraception. Jamaica's current National HIV Strategic Plan (2012-2017) clearly states that 'the Ministry of Health has integrated HIV prevention, treatment, care and support services into the primary health care system with a concurrent strengthening of the STI care and treatment programmes.'²

The NISP 2014 – 2019 was developed through a highly consultative process involving input and representation from government, the private sector; civil society organisations including faith based organisations; youth; PLHIV and organisations representing those living with HIV and AIDS, and international development partners. The goals, priorities and key actions were derived from the situational analysis, SWOT analysis, the NFPB and National HIV/STI Strategic Plans and international best practice. In particular, a review of "Best Practices" was undertaken to inform the integrated strategic planning process.

STRATEGIC DIRECTION AND FRAMEWORK

Guiding Principles

The NISP 2014 – 19 is guided and underpinned by Vision 2030 National Development Plan; the National Strategic Plan on HIV 2012 – 2017; the Millennium Development Goals, the United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/AIDS and the International Conference on Population and Development (ICPD) Programme of Action.

¹ Sexual and Reproductive Health and HIV-Linkages: Evidence Review and Recommendations (WHO/HIV/2009 • UNFPA/2009 • IPPF-HIV 2009 • UNAIDS 2009 • UCSF 2009)

² Jamaica National HIV Strategic Plan (2012-2017) pg. 11

The guiding principles determine the priorities, the design of the interventions, and the approach to integration. The overarching principles of protection, confidentiality, consent and human rights are applicable throughout the plan. The strategy is guided by the following broad principles:

- Political Leadership and Commitment
- Good Governance, Transparency and Accountability
- Addressing structural determinants
- Equity
- Focus on human rights
- Gender Responsive Programming
- A coordinated and coherent response
- Meaningful stakeholder participation
- Greater Involvement of people living with HIV
- A multi-sectoral approach and partnerships
- Reduction of stigma and discrimination
- Recognition of the centrality of sexuality and sexual health
- Evidence-based decision making and programming

Vision

All Jamaicans enjoying optimum health in an environment where their sexual and reproductive rights are respected, protected and fulfilled

Goal

Jamaicans are enabled to achieve high-quality, high impact, equitable and sustainable integrated sexual and reproductive health and HIV services.

Strategic Outcomes

1. Improved access to quality family planning services
2. Reduced incidence of new HIV infections
3. Improved access to quality treatment care and support to reduce HIV-associated deaths.
4. Strengthened policy and legal framework for integrated sexual and reproductive health and HIV prevention, treatment and care services.
5. Strengthened multi-sectoral partnerships to effectively plan, implement, monitor and evaluate programmes within an integrated SRH/HIV framework.
6. Enhanced capacity for the provision of integrated SRH and HIV services within the health sector

Each strategic outcome consists of strategic outputs, which in turn are comprised of implementation plans and activities. It is intended that the NISP will generate further detailed implementation plans for each priority area below as well as at the level of regional health authorities.

Targets

A number of targets are expected to be achieved over the five year period. The key targets are:

1. Reduce by 10% the number of unplanned pregnancies by 2019
2. Reduce the unmet need for contraceptive among all women 15-44 years to 5.7% by 2019
3. Increase contraceptive prevalence rate to 76% by 2019
4. Increase dual method contraceptive use by 20% by 2019
5. Reduce by half, the number of new HIV infections by 2019
6. Increase to 65%, coverage of ARV treatment for PLHIV by 2019
7. Increase to 90% the proportion of PLHIV on ART one year after initiating therapy
8. Reduce the number of HIV related deaths by 25% by 2019
9. Eliminate vertical transmission of HIV by 2015

Priority Areas

The Plan is consolidated around five (5) priority areas with associated interventions/key actions and outcomes. These are built around a policy and programme framework encompassing:

- Prevention and SRH Outreach
- Universal Access to Treatment, Care and Support and SRH Services
- Enabling Environment and Human Rights
- Monitoring and Evaluation of HIV, Family Planning and Sexual Health Responses
- Sustainability, Governance and Leadership

Methodology

The development of the NISP 2014 – 2019 lasted just over one year and included key consultation meetings in many sectors and a comprehensive review of the existing strategic plan on HIV. Meetings held included the following:

- Gender consultation – Many partners including CSOs, IDPs, Jamaica Network of Seropositives, Jamaica Community of Positive Women and UNAIDS reviewed the current progress of the response and agreed on key areas for improvement.
- A series of dissemination and consultation meetings were facilitated in many sectors, reviewing the existing strategic plan and getting feedback on the way forward.
- Faith-based consultations
- The midterm review of the existing plan was also a step in developing the new plan

A wide cross section of stakeholders has contributed to the development of the NISP 2014 – 2019. The NISP was developed after consultations and workshops held with various stakeholders including civil society, persons living with HIV and AIDS, representatives of marginalized groups such as men who have sex with men and sex workers, service providers, programme managers, policymakers and providers of technical and financial assistance. The findings of the preliminary consultations and draft

NISP were presented to key national and regional stakeholders during a strategic planning meeting, to determine the strengths, weaknesses and gaps of the draft NISP. These discussions guided the development of the final National Integrated Strategic Plan on Sexual and Reproductive Health and HIV.

The NISP is intended to assist in overcoming the barriers to improved sexual and reproductive health and HIV prevention and care by providing the framework for implementation of services and activities that are designed to better current conditions.

The total estimated cost over the five years of the plan is....

INTRODUCTION

COUNTRY PROFILE

Jamaica is the largest English-speaking island in the Caribbean with a land area of 10,991 square kilometres and a total population of 2,705,800 (Statistical Institute of Jamaica-STATIN 2010 population figures). 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); and an increasing working age group (52%) and dependent elderly population (11%).

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 15-74 years of age show an upward trend in the prevalence of overweight and obesity, hypertension and diabetes. The aging of the Jamaican population has implications for chronic disease prevalence and management, utilization of health services and the social protection scheme. Of increasing importance is the co-morbid impact of HIV and obesity, hypertension, cardiovascular diseases and drug abuse disorders.³

Sexual and Reproductive Health and HIV

Jamaica's Reproductive Health Surveys (RHS), which began in 1975 (first as Fertility Reduction Surveys and then as Contraceptive Prevalence Surveys before developing into more comprehensive Reproductive Health Surveys) and are conducted roughly every five years, have reported/documenting 'an almost 50% reduction in fertility rates over three decades as well as a 40% reduction in unmet contraceptive needs and a 40% reduction in unplanned pregnancies over the last two decades.'⁴

There are however serious sexual and reproductive health challenges reflected in the reports including falling but still high rates of unplanned pregnancies (over 40%); falling but high rates of pregnancies among adolescent girls (18 per cent of all live births in Jamaica are to adolescents); and a consistent 20% of female respondents reporting that they have been forced or coerced into having sex over a 20 year period. The 2008 survey reports that almost half of all sexually active females, 15-24 years old, said they were coerced into having sex the first time they ever had sex.

The surveys have also flagged the vulnerability of young girls to forced sex and exploitation by older males. An NFPB paper on the 2008 survey notes '46 per cent of females who were under the age of 13 at their first intercourse had a partner that was six (6) or more years older than they were. The percentage of males who had sex at the same age however, with a partner that had the same age

³ 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 med. j.*, 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 24 January 2015.

⁴ Ibid

difference was only 8.4 per cent. This shows the vulnerability of young girls and can have severe implications for their Reproductive Health.⁵

Based on the reports of successive NFPB SRH surveys and the National HIV Programme’s Knowledge Attitudes, Practices and Behaviour (KAPB) Surveys, significant behaviour change with respect to condom use and multiple sexual partnerships has been achieved among Jamaicans. However these appear to have reached a plateau and new approaches, messaging and strategies are needed to ensure increased consistent condom use and a reduction in multiple sexual partnerships.

Notwithstanding the general decline in communicable diseases in Jamaica, HIV continues to be a significant feature among the Jamaican population. The number of HIV and AIDS cases rose steadily from the first documented case in 1982 to an estimated 30,313 people living with HIV (PLHIV) or 1.8% of the adult population in 2013. High risk behaviours such as early sexual debut, multiple sexual partners, high levels of transactional sex, gender inequalities, inadequate condom use and homophobia continue to fuel the transmission of HIV and STIs.

- Number of reported HIV and AIDS Cases in 2014: 30,313
- HIV Prevalence: 1.8%
- Key drivers of the epidemic
 - Early sexual debut
 - Multiple sexual partners
 - Transactional sex
 - Gender inequalities
 - Inadequate condom use
 - Homophobia

Jamaica’s HIV landscape includes features of both a generalized and concentrated epidemic among some key population groups⁶. Key population groups with respect to HIV infection in Jamaica include Men Engaging in Casual Heterosexual Sex (CHS); Female partners of CHS; Men who have Sex with Men (MSM); Female partners of MSM; Sex Workers; Clients of Sex Workers; Partners of Clients of Sex Workers; Injecting Drug Users/Homeless persons and Prisoners.

The HIV epidemic is also closely tied to poverty and related development issues, including the slow rate of economic growth, high levels of unemployment, low educational attainment especially among males, and crime and violence. Moreover, the epidemic threatens national productivity because the majority of cases occur in the reproductive and working age groups.

Since 1988, Jamaica has had a national plan to guide the response to HIV and a well-established National HIV/STI Programme and National AIDS Committee. There is participation of key government ministries and civil society in its various programmes. This multi-sectoral response has succeeded in maintaining adult HIV prevalence at a stable level below 2% since the mid-1990s. The Ministry of Health has also integrated HIV prevention, treatment, care and support services into the primary health care system with a concurrent strengthening of the STI care and treatment programmes. Despite

⁵ NFPB Background Sheet: Data on Adolescent Reproductive Health
http://www.jnfpb.org/pdf/AdolescentReproductiveHealth/Background_on_Adolescent_Reproductive_Health.pdf

⁶ A generalized epidemic refers to an epidemic that has spread beyond specific groups (such as sex workers or MSMs, and drug users, for example) into the whole population. On the other hand, a concentrated epidemic refers to one that is confined mainly to individuals who engage in high-risk behaviour such as the MSMs and sex workers. The general principle of defining a concentrated epidemic is when less than one percent of the general population, but more than five percent of any high-risk group are HIV positive.

Jamaica's success in addressing the epidemic, HIV and AIDS still have the potential to significantly impede the social and economic development of the country and contribute to the poverty gap.

The NISP 2014 - 2019

For years, Jamaica operated a vertical HIV-specific programme rather than building services into existing health systems. Funding for HIV increased significantly between 2004 and 2012 whilst at the same time funding for sexual and reproductive health remained low.

The Framework of Actions for the follow-up to the Programme of Action of the International Conference of Population and Development Beyond 2014 indicates that countries like Jamaica should expedite the implementation of full integration of HIV and other sexual and reproductive health services.

This should include expanding access to 'diagnosis and treatment of sexually transmitted infections, including HIV testing; integrating HIV counselling within sexual and reproductive health counselling including for adolescents and youth; strengthening continuity of care from pre-pregnancy, prenatal to post-natal and child health for all women and children, regardless of HIV status; and addressing the contraceptive needs of all persons, including HIV-positive persons.⁷

Through an integrated approach to addressing **components** of SRH and the HIV response, the Government of Jamaica has demonstrated its commitment to efficiency, sustainability and accountability through a process of public sector transformation and policy and programme harmonisation.

The integrated approach increases the focus on leadership, development and governance to facilitate the seamless integration of HIV into SRH policy and programme development and delivery. It responds to the changing policy and fiscal/funding/economic environment and indicates Jamaica's commitment to the implementation of high impact, cost effective programmes that will result in improved efficiencies and have the potential scale up SRH responses and reduce the impact of the HIV epidemic.

This strategic plan has been developed to give guidance to policy makers, programme developers and implementers in order to ensure provision of relevant, sustainable, integrated sexual and reproductive health services to the Jamaican people. **Specific focus for this inaugural integrated strategic plan will be on family planning; diagnosis and treatment of sexually transmitted infections; HIV prevention, treatment and care and maternal and new-born services.**

Alignment with National and International commitments

The integration gives effect to one of the key strategies outlined in Vision 2030 - Jamaica's National Development Plan, to "expand and improve integration of family planning, maternal and child health, sexual and reproductive health and HIV into primary health care."

⁷ United Nations Population Fund (UNFPA). 2014. The Framework of Actions for the follow-up to the Programme of Action of the International Conference of Population and Development Beyond 2014

The plan is integrally linked to the Sustainable Development Goals (SDGs). Of the 17 proposed goals and 169 proposed targets within the Outcome Document, SRH and HIV and AIDS are specifically referenced in two 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

Goal 3 lays out nine substantive targets to be reached, including:

- 3.1: By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births
- 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
- 3.7: By 2030, 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

Goal 5 includes the following targets to be reached by 2030:

- 5.2: Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation
- 5.6: Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences

Other areas of alignment include the International Conference on Population and Development (ICPD) Programme of Action (1994) and the Glion Call to Action on Family Planning and HIV/AIDS in Women and Children (2004) among other international commitments (**See Annex 4**).

Human Rights Focus

The promotion and protection of human rights is fundamental to a comprehensive integrated SRH and HIV strategy. It will be critical that an environment for all Jamaicans to access non-discriminatory SRH/HIV information, goods and services is created. This will require applying an increased focus on human rights and advocacy to support social change.

Programmes designed to facilitate the fulfilment of these and other human rights are crucial to the country achieving the outcomes of a healthy and stable population and effective social protection as projected by the National Development Plan, Vision 2030. In order for Jamaicans to be empowered to achieve their fullest potential, the barriers that result in the marginalised having limited access to SRH/HIV information, goods and services must be mitigated.

The NISP will refine and clearly articulate the vision, goal and objectives for the Sexual Health Agency and identify relevant and sustainable activities within its mandate and capacity which will contribute to

improved SRH outcomes in specific areas relating to prevention, treatment and care, human rights and the creation of an enabling environment.

CHAPTER 1. THE INTEGRATED APPROACH

The World Health Organization (WHO) defines 'integration' as a concept focusing on targeted services and/or programmes that can be joined together to ensure and perhaps maximize collective outcomes by offering more comprehensive services; this requires specific organizational and management structures/procedures to support such enhanced service delivery (WHO 2009).

Integration refers to combining components of sexual and reproductive health (SRH) and HIV services that are currently separate, with the goal of maximizing coverage and health outcomes for the client and optimizing the use of scarce resources. Integrating services can take various forms: SRH including family planning (FP) services can be integrated into HIV counselling and testing programmes, into prevention of mother to-child transmission services, or into care and treatment programs. HIV testing, prevention, and counselling can be added to existing FP, maternal-child, or primary health care services. SRH and HIV services can be made available in the same location during the same visit and perhaps by the same provider. Services can also be linked by referring a client from one service to another.

Models for integration vary according to the specific mix of services integrated, the foundation or base service into which another service is being integrated, the level of the health system in which integration is evident, and the service delivery structure for integration. In terms of the specific mix of services that are integrated, various combinations of the following services can be integrated: HIV counselling and testing (in its various forms), PMTCT, ART, and in some cases MCH more broadly. The base service is usually determined by country context (history of family planning and HIV programmes, epidemiology, etc.); the strength of the systems in place to deliver this base service is thought to have direct implications for the success of integration efforts.

Integration can occur at various levels of the health system, from national/policy level, to facility or service delivery level, and also down to community level. The modalities for integrating services differ widely as well: services can be co-located (at the level of the individual service provider, the consultation room, or at the level of the facility) or provided through referral services to other providers or separate facilities, which often provide more specialized or stand-alone services. However, it is generally accepted that the mere coexistence of services in the same facility does not constitute integrated services.

1.1 TOWARDS INTEGRATION OF SRH AND HIV SERVICES IN JAMAICA

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. The agency was formed out of the Government of Jamaica's recognition in the early 1960s of problems associated with population growth and the need for family planning among Jamaicans.

In April 2013 the Jamaican Government ratified the integration of the NFPB and the National HIV/STI Programme to create the Sexual Health Agency (SHA) of Jamaica. The Agency emerged at a crucial juncture when the sustainability of the NFPB and of the NHP was in question.

In 2010, faced with a fiscal crisis, the Jamaican government recommended to Parliament that the NFPB be subsumed into the Ministry of Health as a part of its public sector rationalisation proposal. In that same year, Jamaica's new classification by the World Bank as an upper middle income country meant that access to assistance from international donors like the Global Fund, which provide most of the funding to the NHP, would be limited going forward.

In an MOH commissioned case study assessing the process of integration which led to the formation of the Sexual Health Agency, the writers summed up the situation:

At the national level, integration of family planning and HIV/STI programming did not gain traction until 2010. At this juncture, the sustainability of both the Ministry of Health's NFPB and NHP came into question. In different ways, broad economic forces threatened the two entities, inspiring leaders within the MOH to brainstorm a way to achieve another challenging but widely embraced ideal: cutting costs while improving efficiency and effectiveness.⁸

An NFPB Policy Paper (2012) also pointed to these factors as reasons why a decision was made to integrate the NHP into the NFPB in Jamaica.⁹

The Sexual Health Agency was therefore conceptualised and developed out of economic necessity and a need to ensure the sustainability and demonstrate the relevance of entities with a sound track record providing dedicated service (vs. a merged/consolidated service with the MOH) to the specific mandates of HIV and AIDS and SRH with a focus on Family Planning. The anticipated efficiencies and cost savings generated through the integration of both entities was also a very important consideration in light of the public sector rationalisation plans being proposed by Government.

The analytic and decision making process about integration was led by an Integration Committee. The committee's deliberations and decisions were informed by the findings of consultancies which conducted a legal and policy review, an options appraisal, organisational development and vision and strategic planning.

Carr and McClure in their case study and Williams in the NFPB Policy Paper note that the legal expert concluded that transferring the NHP to the NFPB could be achieved with minimal legislative and other effort' as the latter had clear legal status and power which 'allowed it to take on any mandate to which the Minister of Health and the NFPB Board Chairperson agreed.¹⁰

The health systems expert who conducted the options appraisal shared the view that it would be better to integrate the NHP into the NFPB (Carr, McClure).

Carr [a health systems expert] noted that key reproductive health programmes would remain in the MOH head office, potentially resulting in inadequate integration with NFPB programming.

⁸ Carr, Dara and McClure, Kathy. 2014. National Family Planning-HIV Programme Integration in Jamaica-Creating a New Sexual Health Agency. Washington DC. Futures Group. Health Policy Project. pg. 2

⁹ Williams, D. 2012. From Vertical to Integration: Integrating the National HIV Programme with the National Family Planning Programme in Jamaica makes sense. National Family Planning Board.

¹⁰ Carr, Dara and McClure, Kathy. 2014. National Family Planning-HIV Programme Integration in Jamaica-Creating a New Sexual Health Agency. Washington DC. Futures Group. Health Policy Project. pg. 7

The three criteria with the largest difference in favour of NHP-NFPB integration were:

- Impact on the direction and thrust of the programme
- Efficiency and effectiveness in the management of the programme
- Anticipated employee acceptance¹¹

HIV healthcare service delivery (care and treatment, PMTCT) in Jamaica is already being integrated into primary health care, as has been family planning service delivery. Other aspects of RHS such as MCH, STIs have also long been integrated into the healthcare system.

The question of some of the limitations facing the new agency with respect to mandate and possible scope of work was therefore one which had to be determined by the current situation/realities with respect to existing structures and arrangements already delivering components of SRH services and by the existing core functions and strengths of the NFPB and the NHP.

As can be expected, with the announcement of plans for the new integrated agency, stakeholders had varying expectations regarding the role of the agency and the implementation committee itself.

In its Implementation and Completion Report (2013) for Jamaica's Second HIV/AIDS Project, the World Bank for example, in listing Lessons Learned, posited that:

- 'Integration of the HIV response into sexual reproductive health programmes within the ambit of the primary health care response can lead to broader reach and deeper sustained impact.
- The integration of the National HIV/STI Programme (NHP) into the National Family Planning Board (NFPB) to form one executive agency with responsibility for sexual and reproductive health will support the sustainability of the HIV Prevention Component
- The integration of the HIV response into the National Family Planning Board to create a "One Authority" will also help to ensure sustainability.¹²

Carr and McClure noted that:

Early in the integration planning, some stakeholders hoped the new entity would take a comprehensive approach to sexual and reproductive health by addressing maternal and child health, family planning, HIV and other STIs, gender-based violence, adolescent health, and more. As the integration process evolved however, it became evident the new entity would not take this approach.....Instead, the new entity would focus on sexual behaviour as it related to family planning and HIV/STI transmission.....In the [March 2013] Cabinet submission [of a concept paper].....the Ministry [of Health] used the term "sexual reproductive health" – absent the usual "and"- to connote a more narrowly defined scope

¹¹ Carr, Dara and McClure, Kathy. 2014. National Family Planning-HIV Programme Integration in Jamaica-Creating a New Sexual Health Agency. Washington DC. Futures Group. Health Policy Project. pg.8

¹² Implementation and Completion and Results Report for Jamaica's Second HIV/AIDS Project. Document of the World Bank. September 30, 2013.

than is associated with sexual and reproductive health. By October 2013, however, the integration committee determined that the term 'sexual health' better captured their vision for the new entity.¹³

In a presentation to the 20th International AIDS Conference in Melbourne, Australia in 2014, Harvey, Carr and McClure note that the new Sexual Health Agency absorbs the function carried out the NFPB and the NHP except for treatment and clinical services.¹⁴

On 26 March 2013, Cabinet Decision No. 12/13, approval was given 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

This merger resulted in the creation of an organisation responsible for ensuring and guaranteeing the sexual health of Jamaicans through the formation of a Sexual Health Agency—Sexual and Reproductive Health Authority/ “One Authority”— that provides for strengthening the links between HIV and Sexual and Reproductive Health programmes and services through joint policy-making, planning and advocacy. The integration gives effect to one of the key strategies outlined in Vision 2030 Jamaica-- National Development Plan which is to “expand and improve integration of family planning, maternal and child health, sexual and reproductive health and HIV into primary health care”.

The NFPB is now designated as the “National Authority for Sexual Reproductive Health” and its functions include:

- Providing sex education and encouraging the development thereof;
- Undertaking research and dissemination of information in relation to family and population planning;
- Reducing STIs including HIV;
- Improving contraceptive choice and safety; and
- Promoting healthy sexuality

The term ‘National Authority for Sexual Reproductive Health’ was coined to reflect the idea that Jamaica would have a National Coordinating Body that brings together the work of all partners involved in STI, HIV, family and population planning and generally sexual health (SH) issues, and which represents international best practice guidelines for SRH and HIV programming.

The label “**National Authority for Sexual Reproductive Health**” indicates that the NFPB will have the power to collaborate with and support programmes and initiatives implemented by various Ministries,

¹³ Carr, Dara and McClure, Kathy. 2014. National Family Planning-HIV Programme Integration in Jamaica-Creating a New Sexual Health Agency. Washington DC. Futures Group. Health Policy Project. Pg 10

¹⁴ Harvey, K. Carr, D. McClure, K. 2014. Toward Greater Sustainability in Jamaica: Integrating the National HIV and Family Planning Programmes into a new Ministry of Health Agency for Sexual Health-Poster Presentation at the 20th International AIDS Conference in Melbourne, Australia

Departments and Agencies (MDAs) and disseminate and promote information on the specific SRH areas which fall under its expanded mandate. These specific areas are:

- Improving contraceptive choice and safety.
- Reducing STIs (including HIV) and reproductive tract infections.
- Promoting healthy sexuality including adolescent sexual health and
- Reducing harmful practices in an environment where human rights are respected and protected.

Sexual Reproductive Health programmes within the Ministries of Health, Education, Labour and Social Security, Tourism or any other specific sector will continue to be led and executed by the appropriate Ministries and their agencies.

1.2 BENEFITS OF INTEGRATION

Integrating Sexual and Reproductive Health (SRH) and HIV and AIDS services at health and non-health institutions and facilities in Jamaica will be a major landmark in the country's commitment to providing quality care to those affected or at risk of SR ill-health.

Jamaica is signatory to a plethora of global and regional conventions and agendas on health, and the Integrated Strategic Plan on SRH and HIV is aligned with these documents. The justification for the integration of SRH and HIV includes the evidence that the majority of HIV infections in the country are sexually transmitted or a result of vertical (mother-to-child) transmission. In addition, sexual and reproductive ill-health and HIV and AIDS share some underlying causes including poverty, gender inequality and the social marginalization of key populations and other vulnerable groups.

A stronger linkage between SRH and HIV and AIDS programmes should lead to a number of important public health benefits. With careful priority setting based on the UNAIDS Investment Framework, the following benefits are expected to be derived.

- Improved access to and uptake of key HIV and AIDS and SRH services
- Better access of people living with HIV and AIDS to SRH services
- Reduced HIV and AIDS related stigma and discrimination
- Greater support for dual protection against unintended pregnancy and sexually transmitted infections including HIV.
- Improved quality of care
- Enhanced programme effectiveness and efficiency

Integration will also benefit key populations – men who have sex with men (MSM), Sex Workers (SW) and their clients, and people living with HIV (PLHIV). Some of these benefits include:

- Increased coverage for marginalised and under-served populations.
- Access to both HIV and SRH services under the same roof or in the same facility increasing the opportunities for continuity of care without being externally referred.
- Possible reduction of HIV related stigma and discrimination, as HIV treatment and care will be 'normalised' as a core service within a facility.
- Reduction of frequency and costs of health related appointments – as it reduces the need to take additional time out of work to attend appointments, transport costs, etc.

- Expansion of the range of clinical services provided beyond HIV treatment and care to include management and treatment of sexually transmitted infections, congenital syphilis, family planning, cervical cancer screening and treatment, infertility treatment, prevention of mother-to-child transmission and other related services.
- Possible promotion of an increased culture of rights based responses to address the specific needs of people living with HIV.

Beyond the beneficial impact of integration on the fight against HIV, there are gains to be won with regard to improved coverage of family planning (**FP**) services, which is particularly important in a context where unmet need for family planning remains extremely high (Singh and Darroch 2012). Policies that address FP and HIV integration should therefore:

1. Clearly address the importance of FP in HIV prevention and mitigation
2. Establish clear goals for infections averted
3. Lower unmet contraceptive needs among HIV positive women and men, etc.
4. Specify exactly how FP should be addressed in HIV activities
5. Include underserved groups
6. Specify funding sources, including donor, government and others
7. Link well defined indicators to goals
8. Have a monitoring and evaluation plan¹⁵

Integrating HIV and SRH programmes have the added benefit of strengthening the health system and at the same time providing an opportunity to reorient health services towards greater efficiency, effectiveness, quality and responsiveness. While Jamaica has made significant strides in this regard, it was thought that a review of the menu of services towards an essential package of services would be useful. A framework was devised in discussions among senior managers of the Ministry of Health in 1998.

At the Integration Planning Committee Retreat, September 27-28, 2013, an even stronger case for integration was put forward and efforts were made to clearly position the NHP and the NFPB to create and then strengthen the sexual and reproductive health and HIV linkages.

It was agreed that the NFPB operating as the Sexual Reproductive Health Authority would strengthen the links between HIV and Sexual and Reproductive Health programmes and services through joint policy-making, planning and advocacy. Some of the key linkages identified between SRH and HIV were:

- Improved access to and uptake of key HIV and SRH services.
- Greater support for dual protection
- Better utilisation of scarce benefits

¹⁵ Saunders, Rachael. 2006. Implementing Integrated Family Planning and HIV/AIDS Policies and Programs Tools and resources.

- Reduced HIV-related stigma.
- Integration of HIV/AIDS with maternal and infant health

Some of the integrated services that could be carried out by the HIV and SRH Service Providers are:

- Information to prevent unintended pregnancies and HIV/STIs (dual protection)
- Confidential counselling on SRH of people living with HIV
- Addressing the SRH needs of key populations, including men who have sex with men, people who use drugs, sex workers and their clients
- Prevent, diagnose and treat sexually transmitted infection other than HIV
- Refer for prenatal care and high quality obstetrical services

It was therefore emphasised that in order to have an effective and efficient integration process, the Integration Committee should adopt an *Investment Framework /Approach* to:

- Develop and implement an investment logic that outlines the integration process
- Understand the issues and priorities of Sexual Health and HIV in Jamaica.
- Look at the combination and the delivery system of:
 - The Family – SRH
 - HIV Prevention
 - The Linkages of SRH and HIV

What we will do differently



Figure 1 Diagram Indicating UNAIDS Framework

Implementing the Investment Logic

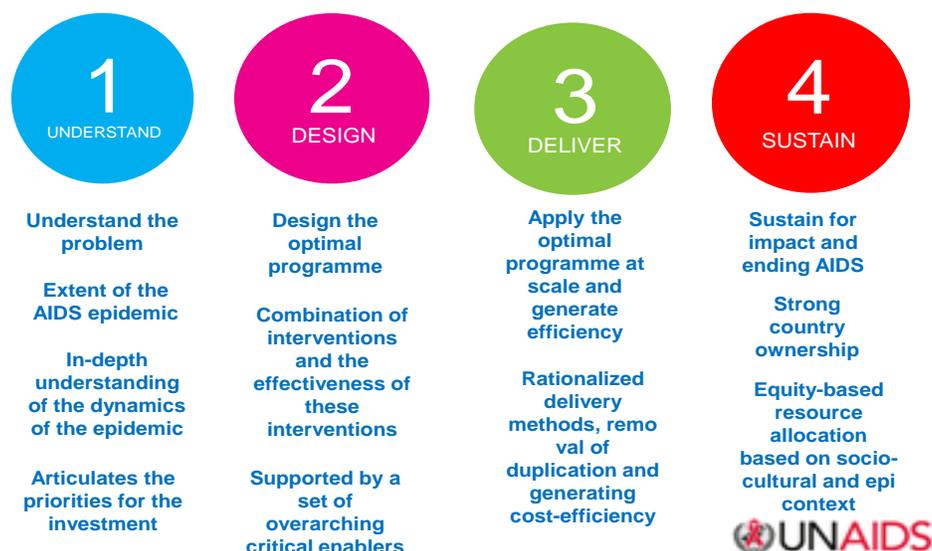


Figure 2 Document of UNAIDS Implementing the Investment Logic

1.3 GENDER INTEGRATION OF SRH/HIV PROGRAMMES

Gender integration is a continuum and the ultimate aim is to move toward gender transformative programmes/policies, thus gradually challenging existing gender inequities and promoting positive changes in gender roles, norms, and power dynamics. Gender transformative approaches actively strive to examine, question, and change rigid gender norms and imbalances of power as a means of reaching health, as well as gender equity, objectives. Gender transformative approaches encourage critical awareness among men and women of gender roles and norms; promote the position of women; challenge the distribution of resources and allocation of duties between men and women; and/or address the power relationships between women and others in the community, including service providers and community leaders.

Gender integration and mainstreaming¹⁶ is important in SRH and HIV programmes. Strategies tailored to meet the unique gender-specific needs and challenges of different beneficiary groups are necessary in order to:

- Increase gender equity in SRH and HIV activities by promoting pro-active and innovative strategies to ensure that men and women, girls and boys, have equitable access to prevention, care, and treatment services; to address barriers selectively faced by women and men in accessing programs and in enjoying program benefits; to mitigate the burden of care on women and girls; and to encourage the greater involvement of men and their uptake of services.

¹⁶ 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."

- Reduce violence and coercion by supporting efforts to change social norms that perpetuate violence against women by: developing screening, couples counselling and partner notification strategies; working with health providers, other institutions and communities to provide a range of support services and referrals for survivors, including the provision of post-exposure prophylaxis (PeP); and by strengthening policy and legal frameworks that outlaw gender-based violence.
- Address men’s norms and behaviours by constructively engaging men in advancing gender equity, preventing violence, and promoting sexual and reproductive health for themselves and their partners, including couples testing and counselling; involving men in prevention of mother-to-child transmission; behaviour change programs addressing alcohol and substance abuse, cross-generational sex, and multiple concurrent partnerships;
- Increase women’s legal rights and protection by eliminating discriminatory policies, laws, and legal practices that deny women enforceable legal rights and protections, by promoting equal rights to land, property and other productive assets; and by increasing awareness among judicial, legal and health sectors, community leaders and authorities on the legal rights related to SRH and HIV.
- Increase women’s access to income and productive resources by strengthening their access to vocational training, education, microfinance and credit so as improve their ability to access services, support themselves and their children, and avoid coercive and high risk activities that increase vulnerability to adverse SRH and HIV.

1.4 JAMAICA’S SRH/HIV INTEGRATION MODEL

The Jamaica NISP defines integration as the “incorporation of some aspects of SRH services into existing HIV services and vice versa.”

The model to be adopted is as per the decision of the Integration Planning Committee (September, 2013), that integration will focus on linking **select** components of SRH and HIV services. These include:

- Services to prevent unintended pregnancies and HIV/STIs (dual protection)
- Confidential counselling on SRH for people living with HIV
- Addressing the SRH needs of key and vulnerable populations
- Prevent, diagnose and treat sexually transmitted infections other than HIV
- Refer for prenatal care and high quality obstetrical services

Health care workers from public facilities will provide integrated SRH and HIV and AIDS services from specified locations. They will be expected to follow prescribed integration guidelines to deliver services to all SRH and HIV clients.

The aim of integration is that all Jamaicans are able to access integrated services at SRH service points in primary and secondary health care e.g. FP clinics, antenatal clinics, post-natal clinics, labour wards, gynaecology clinics, fertility clinics, obstetric clinics. Additionally, patients attending primary care general clinics e.g. curative clinics, chronic disease clinics and other secondary care outpatient departments should be offered SRH/HIV services.

Health care workers from public facilities will provide integrated SRH and HIV and AIDS services from these specified locations. They will be expected to follow prescribed integration guidelines to deliver services to all SRH and HIV clients. These guidelines are to prevent HCWs from being led by personal feelings, beliefs and biases in the provision of HIV and SRH services.

The NFPB has set up a **special SRH and HIV Integration Steering Committee** that will be responsible for guiding the integration process. They will establish guidelines for the integration process as well as monitor implementation of the NISP.

This strategy outlines the *service delivery levels and corresponding service areas with respect to the provision of sexual and reproductive health and HIV and AIDS and the services that are to be integrated*. In view of limited resources and the need for further assessment and planning, only programmes and services that will have the greatest impact will be carried out.

Within a health systems strengthening framework, integration will also include strengthening of the following components:

1. **Service Delivery:** to deliver effective, safe and quality interventions for improving SRH status among those most in need in an acceptable and efficient manner;
2. **Human Resources:** to perform responsively, fairly and efficiently to achieve the best health outcomes given resources and circumstances;
3. **Health Information:** to produce, analyse, communicate and use reliable and timely information on health system performance, as well as health determinants and status;
4. **Medicines and Technologies:** to ensure equitable access to products and technologies that are of assured quality, safety, efficacy and cost-effectiveness;
5. **Health Financing:** to raise adequate funds so that people can use needed services and are protected from impoverishment through having to pay for them, as well as providing incentives for providers to perform efficiently
6. **Leadership and Governance:** to ensure a strategic policy framework exists, together with effective oversight and accountability.

Communities' involvement in the integration process is integral. The plan emphasizes the importance of linking all sectors of government and communities, including nongovernment organisations, Faith-based Organisations, private sector among others, in the implementation mechanism.

Communities contribute significantly to advocacy and service provision. Civil Society Organisations will continue to work with government in these areas within the integrated SRH/HIV framework. Importantly, they will monitor government compliance with integrated programmes which it has committed its resources.

CHAPTER 2. SITUATION ANALYSIS OF SEXUAL AND REPRODUCTIVE HEALTH IN JAMAICA

The Programme of Action adopted at the 1994 ICPD defines reproductive health as 'a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health, therefore, implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.'

The ICPD document notes that reproductive health implies access to information and safe, effective, affordable and acceptable family planning methods and other methods of fertility regulation for men and women, as well as access to health care services 'that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.'

Reproductive health care is therefore defined as 'the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases'. Further, the ICPD frames sexual and reproductive health (SRH) within the context of human rights and sustainable development. This means that SRH should be treated as a fundamental right for all, regardless of gender, sexual orientation or age, to accessible, affordable and appropriate sexual and reproductive health, information, services and commodities.

These globally accepted definitions have guided the spirit and direction of this strategy document which seeks to provide an operational framework for Jamaica's Sexual Health Authority. The availability of resources (human and financial) requires prioritisation in accordance with current needs of a national SRH/HIV programme. As such, this NISP has prioritised the following six components of SRH based on both magnitude and significance of the situation in Jamaica:

1. Family Planning
2. Maternal and Neonatal Health
3. Reproductive Organ Cancer specifically cervical cancer
4. Reproductive tract infections focusing on sexually transmitted infections
5. HIV and AIDS
6. Adolescent sexual and reproductive health

Crosscutting issues that will be addressed include:

- Human Rights including sexual and reproductive rights
- Structural determinants such as gender inequality, poverty, gender based violence

Family Planning

The goal of the Family Planning programme in Jamaica is to continue increasing the number of planned pregnancies and achieve a Contraceptive Prevalence Rate of 75% by 2015.

Jamaica’s fertility rate is 2.4 children per woman. The country has achieved a relatively high contraceptive prevalence rate of 72% and a low unmet need for family planning of 7.2% (RHS, 2008).

The Contraceptive Prevalence Rate (CPR) for women in union has increased steadily since the emergence of the NFPB. An increase in the CPR noted in the 2008 RHS was also confirmed by an increase in estimated users of family planning. This was most recently observed by comparing Monthly Clinic Summary Report (MCSR) data for the years 2011 and 2012.

The majority of unintended pregnancies among contraceptive users occur because of inconsistent or incorrect contraceptive use. Efforts to promote the use of longer acting reversible methods such as the Contraceptive Implant and the Intra Uterine Device (IUD) have had mixed results despite a low failure rate and ease of use. Only 13% of contraceptive acceptors use IUDs and less than one per cent use contraceptive implants compared to 51.4% who use the contraceptive injection. The use of FP methods such as Implants, the Injection, IUDs and Tubal Ligation are options that need to be promoted as they are maintenance-free and have a low margin of error. Improvements in the knowledge and use of these methods can significantly contribute to the achievement of targeted fertility levels.

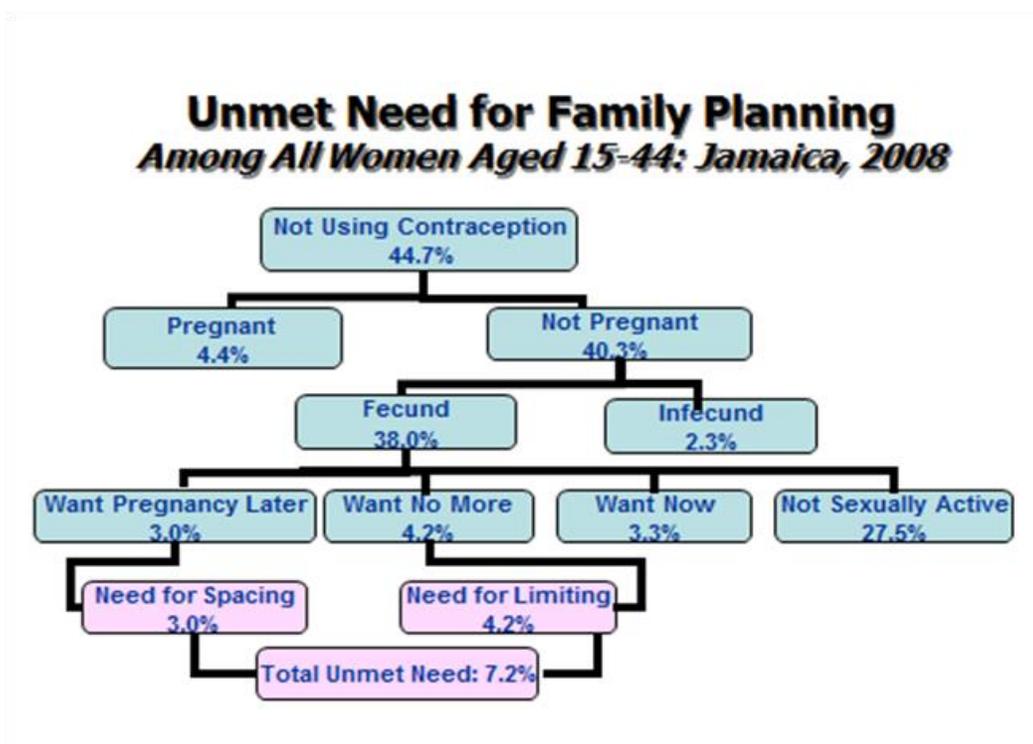


Figure 3 Diagram of Unmet Need for Family Planning among all women aged 15-44: Jamaica, 2008

Instrumental in the achievement of synergy between the HIV/STI response and the Family Planning Programme is Dual Method Use. As can be seen in Table 1 below, there was a fluctuating trend in the total number of persons practising Dual Method Use from 2009 to 2012. A total of 74,781 persons practised Dual Method Use in 2012 (based on Public Sector data), representing an increase of 2.7 per cent when compared with 72,829 users in the year 2011.

Table 1 Number of Dual Method Users 2009 - 2012

Age Group	2012	2011	2010	2009
10 - 19	10,064	9,848	8,255	9,557
20 - 29	35,129	34,476	26,382	31,121
30+	29,588	28,505	21,072	24,896
Total	74,781	72,829	55,709	65,574

Source: MoH CSR Data, 2009 to 2012

Despite these achievements however, it is still critical to reduce the number of unplanned pregnancies and ensure the availability of reproductive health care services and commodities for the reproductive age population. While the percentage of women with unmet contraceptive needs has been falling steadily, as can be seen in figure 1 below, there is still a little over 7 per cent of women whose contraceptive needs are not being met.

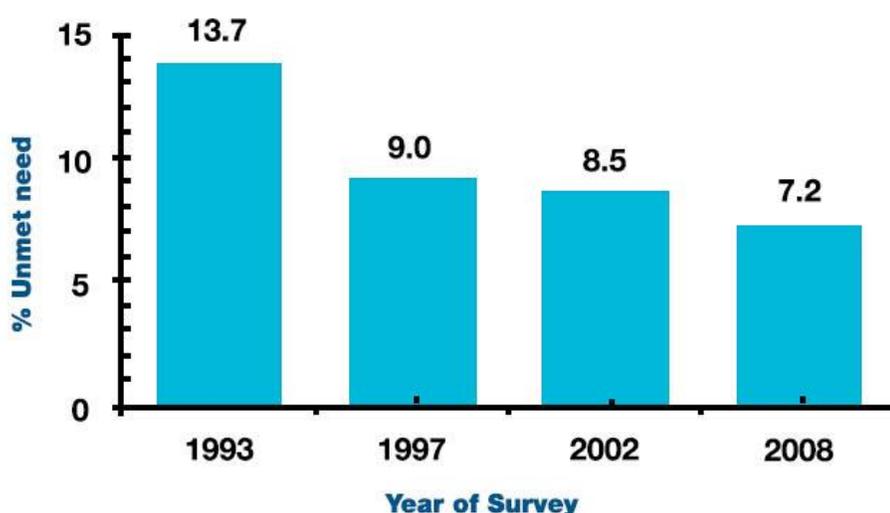


Figure 4 Percentage of Women Aged 15-44 with an Unmet Need for Family Planning

Source: 2002 and 2008 Reproductive Health Surveys: Final Report

The RHS and other data also reveal serious sexual and reproductive health concerns, particularly for women and adolescent girls. While pregnancies among adolescent girls are falling they still remain high – among the highest in the Caribbean region. Some 18% of all live births in Jamaica are to adolescents. Adolescent/Teenage pregnancies also present serious risks to the girls’ physical and mental health and educational and socio-economic prospects.

Maternal Health

There are 18 public and six private hospitals providing maternity care in Jamaica as well as some 320 health centres providing antenatal and post-natal care.

The Jamaica Maternal Mortality Surveillance database indicates that the island's Maternal Mortality Ratio (MMR) in 2013 was 108.7 per 100,000 live births¹⁷. The World Health Organisation's (Global Health Observatory) Maternal Mortality Country Profile for Jamaica¹⁸, estimates that 3% of deaths among women of reproductive age were due to maternal causes in that year. AIDS-related indirect deaths constituted 7.5% of all maternal deaths.

The same data source indicates that since 1990, well over 90% of all pregnant women have had skilled attendance at birth and this figure has been increasing steadily. In 2013 there was skilled attendance at 98.6% of births. The World Bank has reported that 99% of pregnant women in Jamaica receive prenatal care – that is they were attended at least once during pregnancy by skilled health personnel for reasons related to pregnancy. The Ministry of Health's statistics indicate that on average, Jamaican women receive four to five antenatal visits during pregnancy (the World Health Organisation recommends four quality antenatal visits during pregnancy).

Table 2 Direct and indirect maternal deaths, pregnancy to 42 days post-delivery, Jamaica: 2009-2013 by region of residence of the decedent, and place of death

Direct and indirect maternal deaths, pregnancy to 42 days post-delivery, Jamaica: 2009-2013 by region of residence of the decedent, and place of death ¹⁹						
REGION OF RESIDENCE AND PLACE OF DEATH	2009	2010	2011	2012	2013	TOTAL 2009-13
SOUTH EAST REGION RESIDENTS						
KPH/VJH	11	9	8	7	10	45
UHWI	4	4	4	4	2	18
STH	3	7	3	3	2	18
OTHER HOSPITALS	0	2	1	0	3	6
HOME/COMMUNITY	0	0	0	2	2	4
TOTAL MATERNAL DEATHS	18	22	16	16	19	91

¹⁷ Maternal mortality surveillance database, Jamaica. Analysis by A McCaw-Binns, Department of Community Health & Psychiatry, UWI on behalf of the National Maternal Mortality Surveillance Committee, January 2015.

¹⁸ Maternal mortality in 1990-2013 WHO, UNICEF, UNFPA, The World Bank, and United Nations Population Division Maternal Mortality Estimation Inter-Agency Group Jamaica. http://www.who.int/gho/maternal_health/countries/jam.pdf?ua=1 Accessed on January 25, 2015

¹⁹ Maternal mortality surveillance database, Jamaica. Analysis by A McCaw-Binns, Department of Community Health & Psychiatry, UWI on behalf of the National Maternal Mortality Surveillance Committee, January 2015.

LIVE BIRTHS	19,086	17,656	17,312	17,361	17,768	89,138
MMR	94.3	124.6	92.4	92.2	106.9	102.1
NORTH EAST REGION RESIDENTS						
KPH/VJH	0	3	1	0	0	4
UHWI	1	0	0	1	1	2
SABH	1	2	2	2	2	9
ANNOTTO BAY	1	0	0	1	0	2
CRH	0	1	0	0	0	1
OTHER HOSPITALS	0	0	0	0	0	0
HOME/COMMUNITY	0	0	0	0	0	0
TOTAL MATERNAL DEATHS	3	6	3	4	3	20
LIVE BIRTHS	5926	5531	5391	5303	5522	26,673
MMR	50.6	108.5	55.6	75.4	54.3	75.0
WESTERN REGION RESIDENTS						
KPH/VJH	1	0	1	0	0	2
UHWI	0	0	0	0	0	0
CRH	1	2	6	3	5	17
SAV-LA-MAR H	0	4	1	0	1	6
OTHER HOSPITALS	0	1	0	2	2	5
HOME/COMMUNITY	0	0	0	0	3	3
TOTAL MATERNAL DEATHS	2	7	8	5	11	33
LIVE BIRTHS	8376	8163	8282	8090	7696	40,607
MMR	23.9	85.8	96.6	61.8	142.9	81.3

SOUTHERN REGION RESIDENTS						
KPH/VJH	2	0	2	1	0	5
UHWI	1	0	1	1	2	5
CRH	0	0	1	0	0	1
MANDEVILLE REGIONAL	1	2	2	2	7	14
MAY PEN H	2	6	2	1	0	11
OTHER HOSPITALS	2	1	1	1	0	5
HOME/COMMUNITY	0	1	1	2	1	5
TOTAL MATERNAL DEATHS	8	10	10	8	10	46
LIVE BIRTHS	8779	8450	8668	8593	8574	43,064
MMR	91.1	118.3	115.4	93.1	116.6	106.8
JAMAICA						
KPH/VJH	14	12	12	8	10	56
UHWI	6	4	5	6	5	26
CRH	1	3	7	3	5	19
STH	3	7	3	3	2	18
OTHER B HOSPITALS	5	15	7	7	13	47
OTHER HOSPITALS	2	3	1	2	2	10
HOME/COMMUNITY	0	1	2	4	6	13
TOTAL MATERNAL DEATHS	31	45	37	33	43	189
LIVE BIRTHS	42,167	39,803	39,673	39,348	39,560	200,551
MMR	73.5	113.1	93.3	83.9	108.7	94.2

The Ministry of Health notes that while direct maternal deaths have declined significantly, indirect deaths due to HIV/AIDS, cardiovascular disease, sickle cell disease and neoplasms, among others, have increased. The leading direct causes of maternal death are hypertension, haemorrhage, embolism (obstetric), ectopic pregnancies and sepsis due to abortions.

Most maternal deaths occur in women between 20 and 34 years of age having a second or third baby. Age specific mortality ratios show that women over 30, particularly those over 40 years and who have five or more children were most at risk (McCaw-Binns & Lewis-Bell 2009). Gestational hypertension remains the leading cause of death across all age groups, however for teenagers and women 30 years and older, abortion is a significant and highly preventable cause of death.

Reproductive organ cancers

Cervical cancer is the second most common cancer among women worldwide and is the leading cause of deaths in developing countries. The age-specific rate in the Caribbean is 33.5/100,000 with a rate of 27.9 per 100,000 in Jamaica. The death rate in Jamaica is 15.8 per 100,000 risk of developing cervical cancer. Current estimates indicate that every year 392 women are diagnosed with cervical cancer and 185 die from the disease.

The Jamaica Reproductive Health Survey (2008) indicates that only 43% of reproductive aged women (15-49 years) reported ever having a routine gynaecological exam and 62% had received a Pap smear test to screen for cervical cancer.

Cervical cancer ranks as the 2nd most frequent cancer among women in Jamaica and the 2nd most frequent cancer among women between 15 and 44 years of age. Data is not yet available on the HPV burden in the general population of Jamaica. However, in the Caribbean, about 15.8% of women in the general population are estimated to have cervical HPV-16/18 infection at a given time and 57.6% of invasive cervical cancers are attributed to HPVs 16 or 18 (ICO Information Centre on HPV and Cancer, 2014).

Cervical cancer screening has greatly reduced morbidity and mortality but has its limitations. It does not prevent HPV infection or development of early pre-cancerous changes in the cervix. In some cases the disease progresses quickly and may not be detected in time.

Secondary prevention of cervical cancer by doing pap smears yearly from age 21 is the standard recommendation for all women whether or not one is sexually active. Primary prevention of cervical cancer by the use of vaccination is the way forward. There is a vaccine available that is effective in reducing persistent infection from HPV types 16, 18, 45 and 31 and over several years will reduce the incidence of cervical cancer and other HPV-related cancers of the genital tract in women. The vaccine has been shown to be safe, effective and well tolerated by women and children from age 10 years to age 55 years. The vaccine is FDA approved.

Reproductive Tract Infections/Sexually Transmitted Infections

The surveillance and reporting of sexually transmitted infections (STIs) in Jamaica is mandatory and is done on a consistent basis. Treatment facilities for STIs are available with at least one facility in each parish.

There has been a steady increase in the total number of patients visiting STI clinics every year since 2007. This is primarily due to increases in the number of revisits as the number of new cases has declined from

26,382 in 2012 to 21,649 in 2013 (See Figure 5). Men represented 29% of the total number of new clients attending STI clinics in 2013 (Figure 6).

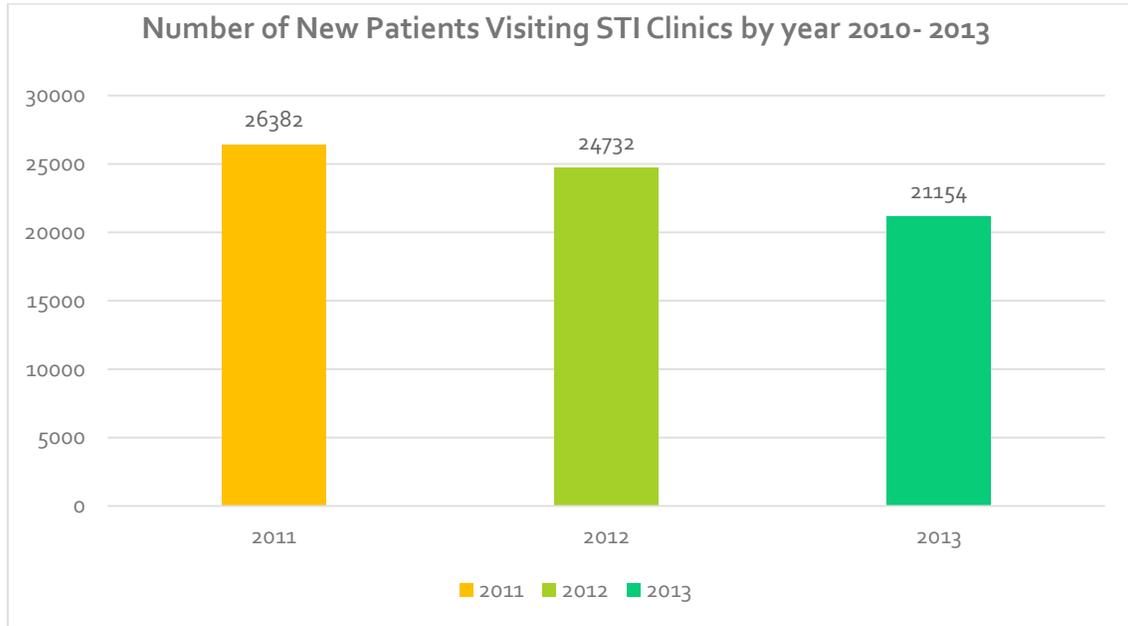


Figure 5 Number of new patients visiting

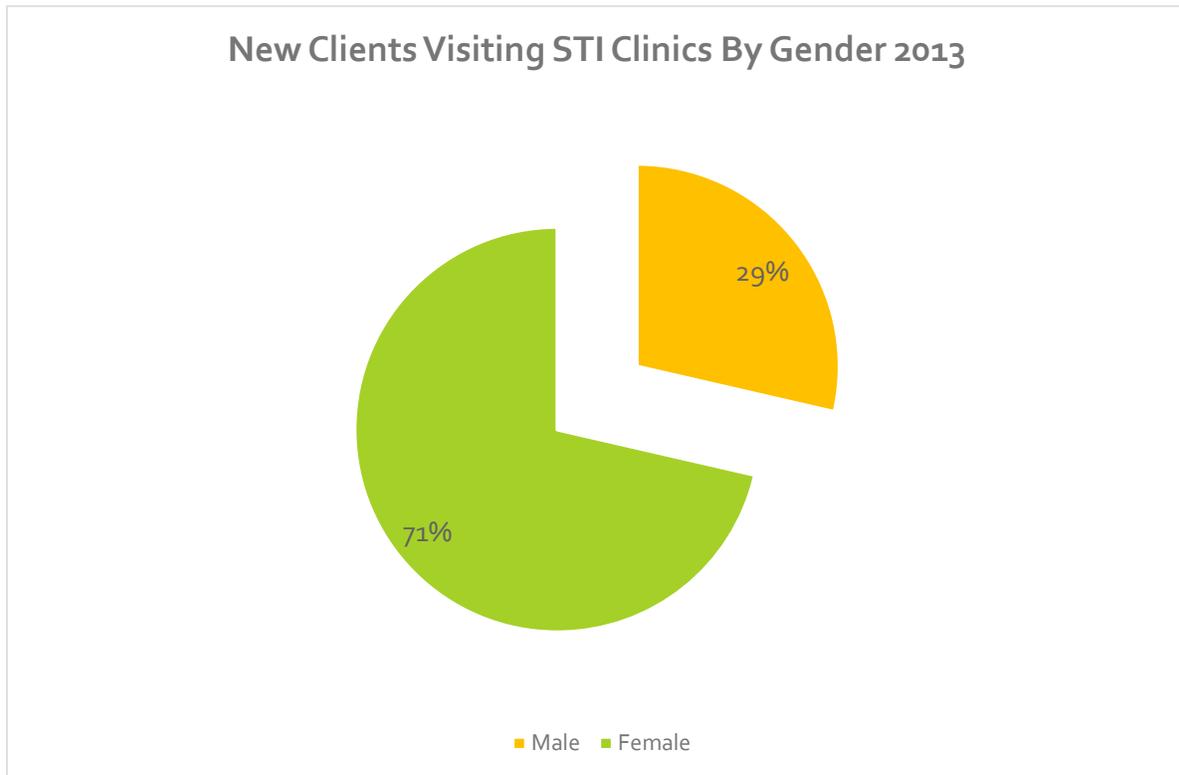


Figure 6 New Clients visiting STI clinics by Gender 2013

Sexually Transmitted Infections (STIs) were more frequently reported in the 20 -24 year old age group followed by the 15-19 year old group. In 2013, the Age Specific Genital Discharge Syndrome (GDS) per 100,000 populations for persons aged 20 – 24 years old was 3498 and 2401 among those aged 15 – 19 years old. Genital Discharge Syndrome includes candidiasis, gonorrhoea, chlamydia and trichomoniasis.

Of significance, also is that women record the greatest number of cases of GDS with as much as 3 to 5 times as many cases as men. The disparity is linked to a combination of factors including greater susceptibility of women to STI and higher health seeking behaviours and detection bias among women.

Disaggregation by age of genital ulcer diseases (GUD) - which include syphilis, chancroid, herpes simplex virus (HSV), granuloma inguinale (GI), and lymphogranuloma venereum (LGV) - also showed the highest rates among persons in the 20-24 age groups, followed by the 15 – 19 year olds. Herpes and syphilis accounted for 83% or 761 cases of reported GUD in 2013 while unspecified ulcerative diseases made up 11% of cases, also chancroid and GI/LGV) represented 5% and 1% GUD cases respectively

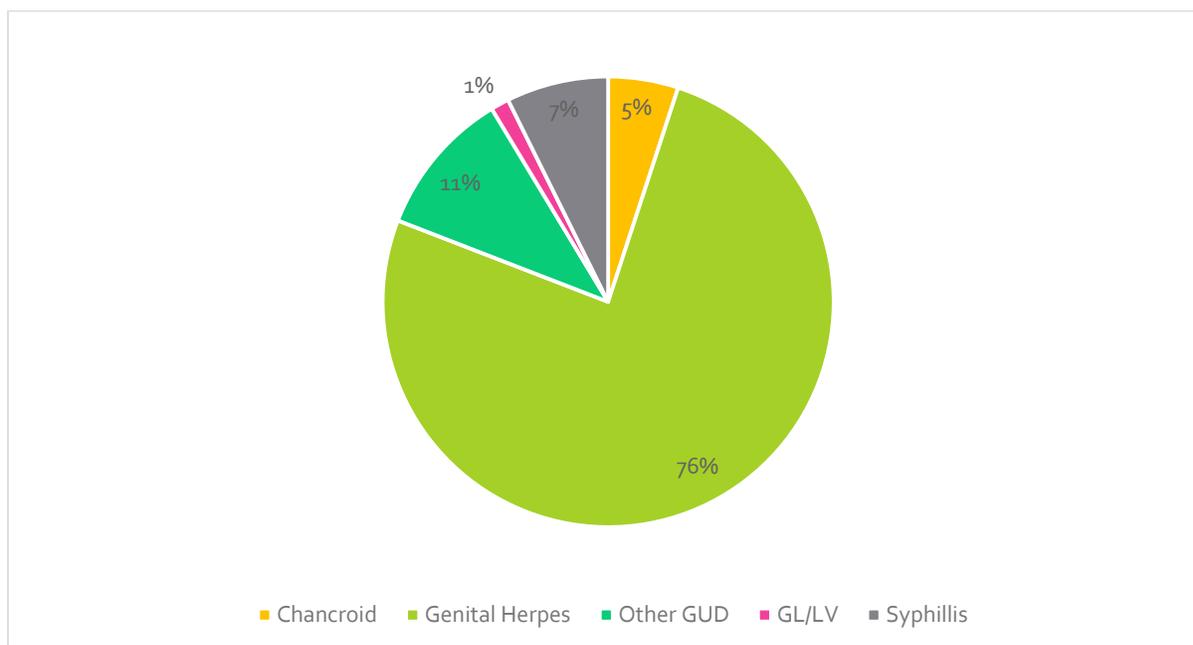


Figure 7 Distribution of the causes of Genital Ulcer disease 2013

The National Strategic Plan on HIV and AIDS (2012- 2017) highlights the need to expand testing of other STIs other than HIV with a focus on key populations, as well as the strengthening of the contact tracing services, as strategic measures to ensure the continued decline.

HIV

Since the first case of AIDS was identified in 1982, 33,198 cases of HIV have been reported with a total cumulative number of AIDS deaths being 9,278 (as at the end of 2014). All 14 parishes are affected by the HIV epidemic but the most urbanized parishes have the highest cumulative number of reported HIV

cases (St. James – 2,195.9 cases per 100,000 persons and Kingston & St. Andrew – 1,656.2 cases per 100,000 persons). Parishes with significant Tourism based economies have the next highest level of cumulative number of reported HIV cases since the start of the epidemic: ranging from 1053.5 per 100,000 persons in Trelawny to 1257.9 cases per 100,000 persons in St. Ann. (See Figure 6).

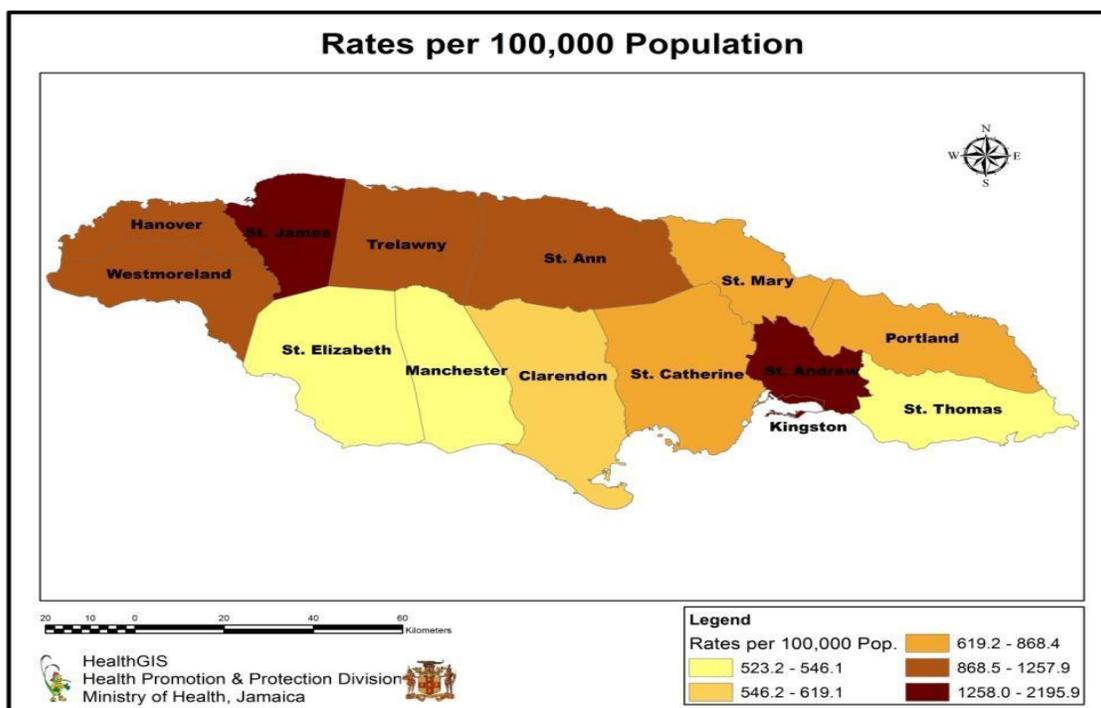


Figure 8 Cumulative reported HIV case rates per 100,000, 1982–2012

As at 2013, Jamaica had an estimated 29,260 persons living with HIV or 1.8% of the adult population²⁰. Approximately 19% of these persons are unaware that they are infected.

Cross sectional studies show higher HIV prevalence in key populations such as men who have sex with men (MSM) (31.4%) and female sex workers (FSW) (2.9%). From MoH surveillance data, the prevalence among other vulnerable populations such as homeless/drug users is 4% and 3.3% among inmates.²¹ MOH surveillance data for 2010 - 2012 show that 4 - 7% of adult hospital admissions are HIV positive and the STI clinic prevalence is 2.4%.

Although injecting drug use (IDU) is not a significant mode of transmission there have been increasing reports of HIV cases through this mode. Over a five year period from 2008-2012, 43% of all HIV cases reported among drug users have been IDU. This trend can possibly be attributed to the expansion of programmes among homeless drug users as well as migrants deported to the island particularly from the United Kingdom or North America.

Approximately 74% of all AIDS cases occur in the age group 20-49. Men still carry a higher burden of the disease however over the years the case rate of women has increased and the gap between men and women has decreased. Prior to 1995 women accounted for 37% of AIDS cases and between 2009

²⁰ Spectrum estimates, 2014

²¹ Ibid

and 2012 they accounted for 46% of AIDS cases. The MOT study of 2011 suggests that increasing prevalence among women may be due to exposure through sex with men who have sex with other men or other high risk male partners. Females account for the majority of reported AIDS cases up to age 29 years old.

The distribution of the incident cases supports the characterization of a concentrated epidemic however the Modes of Transmission Study 2011 (MOT) modelling results reinforces that HIV is not isolated to high risk groups and that key populations groups could act as bridge to the general population, thereby leading to the epidemic becoming generalized over time. Key groups that constitute the concentrated epidemic include female sex workers, men who have sex with men, the homeless, and inmates. These key populations are by no means mutually exclusive and 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 use.²²

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 high (20.3%). Among FSW, the proportion of those with 'any STI' (of gonorrhoea, chlamydia or syphilis) was 20.2% among those aged 15 - 24 years compared to 15% in older FSW; and co-infection between HIV and STI was also higher among FSW aged 15 - 24 years (6%) than the older sex workers²³.

Adolescent Sexual and Reproductive Health

Adolescents ages 10 – 19 constitute 20% of the total population in Jamaica (Jamaica, 2014).

The 2008 RHS has flagged the vulnerability of young girls to forced sex and exploitation by older males. The survey records an average age of sexual debut among males to be 14.5 years and among females 16.1 years²⁴. Child sexual exploitation, transactional and age disparate sex are also common during this period and both have been linked to poverty, income inequality and inadequate enforcement of protection of children from sexual exploitation despite clear legal provisions.

An NFPB paper on the 2008 survey notes '46% of females who were under the age of 13 at their first intercourse had a partner that was six (6) or more years older than they were. The percentage of males who had sex at the same age however, with a partner that had the same age difference was only 8.4%. This shows the vulnerability of young girls and can have severe implications for their Reproductive Health.'²⁵

The issue of sexual violence is also a serious one. A consistent 20% of female respondents to the RHS have been reporting that they have been forced or coerced into having sex. The 2008 survey reports

²² 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.

²³ ibid

²⁴ Statistical Institute of Jamaica. 2010. Reproductive Health Survey, Jamaica 2008. National Family Planning Board.

²⁵ Maternal mortality in 1990-2013 WHO, UNICEF, UNFPA, The World Bank, and United Nations Population Division Maternal Mortality Estimation Inter-Agency Group Jamaica. http://www.who.int/gho/maternal_health/countries/jam.pdf?ua=1 Accessed on January 25, 2015

that almost half (48.8%) of all sexually active females, 15-24 years old, said they were coerced into having sex the first time they ever had sex.

Transactional sex is reported among 24% of adolescent girls aged 15 – 19 years and among 54% of boys aged 15 – 19 years (Knowledge Attitudes Practices and Behaviours Survey, 2012).

HIV prevalence among young adolescent girls and boys aged 10-14 is equal and estimated at 0.1%²⁶. Infection among this group is predominantly the result of mother-to-child transmission of HIV²⁷.

In later adolescence (15 – 19 years), there is an estimated increase in HIV prevalence which is consistent with the onset of sexual behaviour. There is an estimated 4 to 5-fold increase in HIV prevalence in adolescents by the age of 19 years resulting in HIV prevalence of 0.4 - 0.5% among both boys and girls. 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.

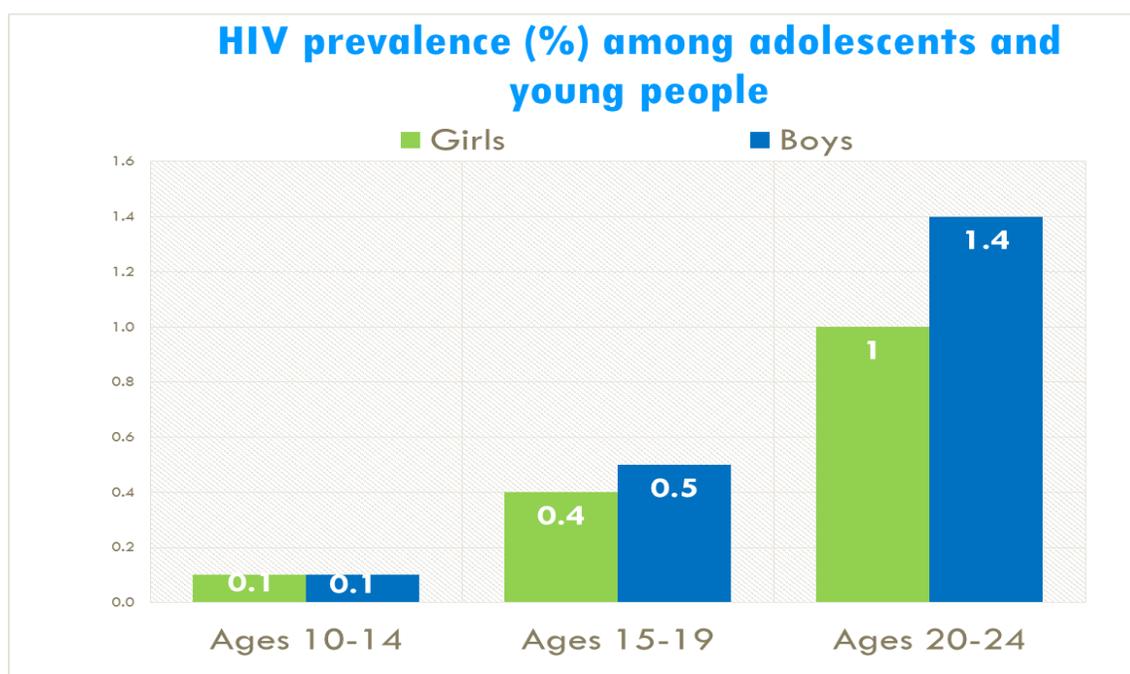


Figure 9 HIV Prevalence in Adolescents Aged 10 - 19 and Young Adults 20 – 24 by Age and Sex

Source: UNAIDS 2013 HIV and AIDS estimates, via Spectrum, August 2014

The HIV estimates suggest that across Jamaica, there are an estimated 685 adolescent girls (aged 10 – 19) living with HIV and an estimated 825 adolescent boys living with the HIV including long-term survivors of MTCT, and behaviourally infected adolescents (UNAIDS, 2014).

²⁶ HIV prevalence estimates are based on the final UNAIDS HIV and AIDS estimates for Jamaica (August 2014).

²⁷ UNAIDS. 2014. HIV Estimates (Spectrum).

Reported AIDS cases however indicate a disproportionate number of females reporting in the age group 15 – 29 years old. There are four times more reported cases among females in the 15 – 19 age range than males (209 females vs. 52 males). In the age group 20 – 24, there were 700 reported cases of AIDS among females compared to 448 among males and in the 25 – 29 age range, 1268 cases were female compared to 1067 males²⁸.

2.1 FACTORS DRIVING ADVERSE SRH OUTCOMES

Both sentinel and case-based surveillance data confirm that adverse SRH outcomes in Jamaica are driven by behavioural, economic and socio-cultural factors. Some of these factors include multiple sexual partnerships, early sexual debut, high levels of transactional sex, sex work and inadequate condom use. These risk behaviours are significantly higher among men than women although women tend to under report risk behaviour more than men since sexual risk behaviours tend to be more culturally acceptable for men than for women.

Values and norms related to constructs of masculinity and femininity; ability to cope with the unstable economic and family environment; sexual relationships in terms of gender inequalities as well as sexual and physical abuse all impact sexual risk behaviours (Kempadoo, 2006) and sexual and reproductive health outcomes. These cultural factors increase vulnerability by promoting multiple partnerships, inter-generational sex, new partner acquisition, early sexual debut and concurrent sexual relationships.

2.1.1 GENDER AND SRH

Gender roles, gender stereotypes, and the control of power and resources can result in adverse sexual and reproductive health (SRH) outcomes. Many sexual and reproductive health problems are directly linked to gender inequity, including unintended pregnancies, the feminization of the epidemic, gender-based violence and maternal mortality.

The primary modes of transmission of HIV are through unprotected sexual intercourse both among men and women. Gender norms and cultural practices relating to sexual behaviour put women and girls at risk and include the pressure to prove womanhood through early pregnancies and multiple partnerships. Other social and traditional standards for appropriate feminine behaviour also help to drive the epidemic. For example, women are expected to conform to men's sexual requests. This means that they are not expected to take the leadership in sexual overtures. Deep rooted gender norms make women believe that they must be unquestioning of the sexual honesty of their male sexual partners, especially their husbands, bear children as a legitimization of womanhood from an early age, or even believe that violence is a sign that a male sexual partner loves her.

Traditional gender norms also direct the behaviour of men and drive them into simultaneous multiple relationships with women, as well as into unprotected sex. Fathering children is deemed to imply virility, male prowess, and that a man is not homosexual, a significant taboo in Jamaica. There is also the belief that beating a sexual partner is a sign of love. The belief that a man can be cured of STIs when he has sex with a virgin drives sexual violence against young girls. These cultural norms encourage men to

²⁸ National HIV/STI/TB Programme data presented at 25th National HIV Treatment Review. November 2015

engage in practices that have implications for adverse sexual and reproductive health and HIV transmission for themselves and their sexual partners.

Research has shown that gender inequalities, poverty and the disempowerment of women — low status, lack of power, lack of access to information, limited mobility, lack of decision making and choice, early age of onset of sexual intercourse and violence — all contribute to maternal mortality and morbidity. Women’s lack of access to family planning or lack of decision- making ability regarding how often and when to have children often results in high fertility and unintended pregnancies. Where access to financial resources is limited, and access and use of SRH services is restricted, decisions about pregnancy and family size may be strongly influenced or independently determined by men.

The feminization of the HIV epidemic – particularly among younger age cohorts (10-19 years of age) - is also largely attributable to unequal gender power relations which impede women’s capacity to negotiate safer sex practices. In addition, traditional, societal norms of masculinity enable men to engage in sexually risky behaviours with negative health consequences for themselves and their partners.

Gender-based Violence

Gender-based violence (GBV) describes any violence rooted in gender-based power inequalities and gender-based discrimination. It includes intimate partner violence, sexual assault and harassment, trafficking of women and girls, and threats of such acts. Gender based violence (GBV)²⁹ increases social vulnerability and is most often perpetrated by males against females. Cultural attitudes that dis-

empower 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*).

Regional research, including Jamaica, on Intimate Partner Violence (IPV) showed that in terms of “perpetration between partners, there was no gender differential at higher levels of violence.” (Le Franc, 2008: 418). In Jamaica 73% of the women and 57% of the men reported “any sexual coercion” in relationships. Perpetrators of violence were reported to be on both sides, with female as well

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as male battering (Le Franc et al., 2008). Males were twice as likely as females to report “having been pressured to have sex” – 15% males vs. 8.8% females (Hope Enterprise, 2008: 29). A pattern that is similar in 2012 when the Knowledge, Attitude, Practice and Behaviour (KAPB) survey shows that men and women who had been sexually active over the past 12 months, report that: “Violence was almost as pervasive among men (5.7%) as among women (6.8%) in the relationship.”(Hope Enterprises, 2012: 59).

²⁹ 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)

Gender Inequalities among key populations

Persons whose sexual orientation, gender identity and gender expression³⁰ do not conform to societal norms - Lesbian, Gay, Bisexual, and Transgender (LGBT) population as well as female sex workers who deviate from the traditional notion of appropriate feminine behaviour - are particularly at risk of a number of adverse SRH and HIV outcomes. They represent a direct challenge to patriarchal, traditional gender norms and roles by not conforming to socially sanctioned gender roles and stereotypes of men and women.

Gender inequalities between and among categories of men and women— or those who assume feminine and masculine behaviours and roles such as transgender persons – are an underlying determinant of HIV risk and vulnerability in Jamaica. Social vulnerability for males is related to cultural norms of the dominant (heterosexual) masculine identity which is associated with having multiple sex partners, virility, having sex without using a condom and poor health seeking behaviour, Bombereau and Allen, 2008).

Gender inequalities and non-conformity in sexual orientation, gender identity and gender expression may result in:

- high levels of stigma and discrimination, harassment, and gender-based violence;
- increase in other social vulnerabilities including mental health problems and poverty;
- barriers to accessing prevention, treatment and care services and information by staff at healthcare facilities who may not separate their accepted gender norms and values from their professional roles and who in deny or limit access to persons.

Health-seeking behaviour

Fear of stigma and discriminatory consequences may affect HIV-related health-seeking behaviour for women and men differently. Regardless of sexual orientation, men may be reluctant to be tested or treated for HIV due to the fear of being stigmatized by peers and the community for having sex with other men. Women may avoid seeking testing or treatment for HIV, even in the context of preventing the mother-to-child transmission of HIV, out of fear that their partners and their community will reject, abandon or act violently towards them and/or blame them for bringing HIV into the family.

Gender and Treatment

Different roles and needs of males and females tend to affect HIV treatment compliance. Advice for taking medicines may need to take into account differences in daily routines, working environments, literacy levels, budgets and the need for social care.

Men may require treatment support in terms of opportunities, time and spaces at workplaces, whereas women may need such support as well as household- or community-based treatment support, including care for children, older household members and other family members that test positive.

³⁰ Sexual Orientation describes an individual's enduring physical, romantic and/or emotional attraction to another person. Gender identity and sexual orientation are not the same. Transgender people may be straight, lesbian, gay or bisexual. For example, a man who transitions from male to female and is attracted to other women would be identified as a lesbian or a gay woman. Gender Identity describes one's internal, personal sense of being a man or a woman (or a boy or a girl). For transgender people, their birth-assigned sex and their own internal sense of gender identity do not match. Gender Expression is the external manifestation of one's gender identity, usually expressed through "masculine," "feminine" or gender-variant behaviour, clothing, haircut, voice or body characteristics. Typically, transgender people seek to make their gender expression match their gender identity, rather than their birth-assigned sex.

Some gender norms relating to communication and problem-solving patterns may affect how and how often men and women seek support for HIV treatment. Norms for masculinity that tend to downplay help-seeking may discourage men and boys from revealing their HIV status and/or asking for support.

Women and girls, in contrast, may be encouraged to share and seek help. These norms may influence their willingness to participate in HIV groups and other support networks that provide emotional, mental and practical help for treatment preparation and adherence. Women may require counselling on the fear of and/or potential side effects of antiretroviral drugs. For example, pregnant women may fear that anti-retroviral drugs will harm the foetus and therefore refuse to take them.

Health and social outcomes and consequences

As HIV infection is a chronic and debilitating condition, entire families (and especially women) are significantly burdened by the need to care for infected individuals. Boys and girls are likely to undergo emotional stress when their parents reveal their HIV-positive status, fall sick or die. HIV-related communication problems, stigma and social exclusion negatively affect men and women themselves and their entire family. However, women more often than men experience physical assault, abandonment by spouse or family, violent threats and property being taken away.

2.2 ECONOMIC CONTEXT

For the last two decades, Jamaica's economy has been characterized by slow growth and high debt. Jamaica's debt was estimated at 146.2% of GDP in March 2013, making the country one of the most indebted middle income nations in the world. Since 2008-2009, Jamaica has also experienced a slowdown in economic growth, reduced access to capital markets, reduction in employment in critical sectors, worsening balance of payments and declining foreign direct investment. In addition, there have been clear signals that external contributions that accounted for more than two-thirds of all financing for the NHP over the past decade will either cease or be significantly reduced over the short-term.

The global economic recession that began in 2008 poses a direct threat to the solid gains made by Jamaica in the development arena. Globally, assistance by major donors to developing countries like Jamaica fell by nearly 3% in 2011 representing the first drop since 1997 and it has been projected that continuing tight budgets in the world's largest economies will put increasing pressure on aid levels in the coming years.

In May 2013 the International Monetary Fund (IMF) approved a four-year Extended Fund Facility (EFF) yielding a total support package of US\$932 million to facilitate the Government of Jamaica's (GoJ) economic reform agenda to stabilize the economy, reduce debt and create the conditions for growth and resilience.

In coordination with the IMF, the World Bank and the Inter-American Development Bank (IDB) have each allocated US\$510 million over the same period to support these efforts. A feature of this support is tightened fiscal policy to govern social spending. This is within the context of an increasing poverty level between 2010 and 2012 when rates moved from 17.6% to 19.9%.

From a macroeconomic standpoint Jamaica's economy continues to contract, thereby compromising the achievement of national development goals. The country's poor economic performance over many

years was due to several factors including structural imbalances in the economy, the effects of globalisation and the global economic crisis, poor fiscal management over the years; high rates of crime and violence and natural disasters.

Additionally Jamaica's classification as an upper middle income country by the World Bank has affected the country's ability to qualify for international aid from some sources, which has implications for the sustainability of various government programmes, including health (Planning Institute of Jamaica, 2004). Medium term cost projections estimate that the cost of implementation of the HIV response between 2017 and 2023 will be approximately J\$17.2 billion or US\$15.4 million³¹. The cost of provision of ART will also increase as the life expectancy of PLHIV on ARTs increases through successful ART delivery and as the number of persons being treated increases with the introduction of the 2013 World Health Organization (WHO) guidelines.

Currently, the Government of Jamaica supports the paediatric component of the HIV programme. The bulk of the funding for ART procurement is from external sources³², however two threats face the financial sustainability of the programme. First is the continuing decline in external sources of funding as the global recession has contributed to a decline in available funds from these international bodies. Secondly, injection of matching funds from the Government of Jamaica will also decline as the financial constraints faced and limitations on spending are brought to bear by the IMF.

The MOH budget allocation for 2011 and 2012 show a steady commitment from the GOJ. Of the overall budget allocated, the MOH received JA\$34.599B or (US\$407,049M) in 2011/12 and JA\$32.386B (US\$359,853M) in 2012/2013.

Over the past 10 years, the national HIV response has been financed primarily through a loan agreement with the International Bank for Reconstruction and Development (IBRD/ World Bank), grants from the Global Fund to fight AIDS, Tuberculosis and Malaria (GF) and the United States Agency for International Development President Emergency Plan for AIDS Relief (USAID/PEPFAR). The Government of Jamaica has in recent times signalled an increasing commitment to the fight against HIV and AIDS as reflected in the 2011/12 and 2012/13 budget cycles when the NHP accounted for 3.90% and 4.05% of the MoH budget. Within the capital B portion of this amount, the sum purely dedicated to supporting the NHP stood at JA\$1.348B (US\$15.866M) and JA\$1.310B (US\$14.562M) for the corresponding two (2) years respectively.

Against the background of the country's contracting economy, the global financial crisis and the reduction in external funding, a major concern is the potential loss of gains due to challenges in the wider health system which limits the full integration and expansion of HIV and SRH services necessary to achieve and maintain sustainability.

³¹The projections utilize an exchange rate of J\$112 to US\$1.

³² Jamaica Sustainability Framework 2013 and the NHF/PAHO Report on the Jamaican Health Sector.

CHAPTER 3. SEXUAL AND REPRODUCTIVE HEALTH IN JAMAICA: ACHIEVEMENTS AND CHALLENGES

Jamaica has made significant gains in ensuring and improving the sexual and reproductive health of its people, including in the components that are included in this integrated strategy - family planning, maternal health, reproductive organ cancer, reproductive tract infections, HIV prevention, care and treatment and adolescent reproductive health.

The following are some of the more significant achievements:

3.1 ACHIEVEMENTS

Family Planning

Jamaica has a relatively high contraceptive prevalence rate of 72% and a low unmet need for family planning of 7.2% (RHS, 2008). There has been roughly an 18,000 increase every year since 2007 in attendance at family planning clinics until 2011 where there was an increase of 16,696. In 2012 the number of adolescent women accessing family planning services was 30,213, or just about 10% of the total population of women accessing services, a statistic that has remained steady since 2007 (NFPB, 2012)

The Contraceptive Prevalence Rate (CPR) for women in union has increased steadily since the emergence of the NFPB. Notably, in the past three RHS survey years, the CPR has increased from 65.9 to 72.5 per cent. The CPR is highest among those women in the age group 20-24 years (75.5%) and the lowest for the 45 to 49 age group (61%).

Maternal and New-born Health

According to the Jamaica Health Ministry, there has been much improvement in maternal and reproductive health care and services including high-risk antenatal clinics in each parish and quarterly maternal mortality reviews in each health region; the implementation of a comprehensive maternal record booklet to cover three pregnancies and give anticipatory guidance to pregnant women; expansion of specialist obstetric and paediatric services to more hospitals throughout the island; and on-going audits of maternity and new-born services for quality assurance.

In 2013 there was skilled attendance at 98.6% of births in Jamaica and 99% of pregnant women in Jamaica receive prenatal care, based on data from the World Bank.

Voluntary counselling and testing for HIV in antenatal clinics is well accepted, with over 95 per cent uptake by pregnant women and ARV treatment or prophylaxis for 92% of HIV infected mothers in the public sector. The Prevention of Mother-to Child Transmission (PMTCT) programme has resulted in more than 97% of HIV-exposed infants getting ARVs (nevirapine and zidovudine) to prevent HIV. This translates into mother to child transmission rates of HIV during 2014 of 1%.

Sexually Transmitted Infections

Between 2011 and 2013, the number of cases of genital ulcer disease (GUD) declined, with the most significant decline taking place between 2012 and 2013. Over the latter period, the number of cases of infectious syphilis declined by 4 per cent among men and by 29 per cent among women. Two age groups

recorded slight reductions in reported infectious syphilis cases for 2012 - those aged 20 – 24 and 30-34 years.

The introduction of rapid, point of care testing for Syphilis HIV Programme has fast-tracked the availability of results. This has resulted in improved patient outcomes (and that of their contacts). The focus on the Elimination Initiative (surrounding vertical transmission of HIV and Syphilis) has also given further attention to the STI Programme. Whilst the clinical successes are apparent (evidenced by the little/no cases of Congenital Syphilis seen annually), the lack of data surrounding Syphilis (and by extension the other STIs), has brought into sharp focus the need to revamp the programme.

HIV and AIDS

Since 1988, Jamaica has had a national plan to guide the response to HIV, and a well-established National HIV/STI Programme and National AIDS Committee. The National HIV/STI Programme (NHP) located within the Ministry of Health was mandated by the Government of Jamaica to coordinate and lead the implementation of the national HIV/AIDS response. The NHP was developed as an expansion of the former Sexually Transmitted Disease (STD) Control Programme, which had been established in 1930.

There is participation of key government ministries and civil society in the NHP's various programmes.

As the programme's capacity expanded, so did its collaboration with funding agencies, other public sector organizations, and the rest of civil society. The cadre of implementing agencies involved in the national response includes all government ministries, the tripartite team of government, employers and workers, the business sector and non-governmental organizations including faith-based entities. All have been supported through technical and financial inputs from NHP.

Since 2004, Jamaica has rolled out free anti-retroviral (ARV) treatment in the public health care system. In 2013, 23 treatment sites that were integrated in the primary health care system provided care to PLHIV in Jamaica. Since then, there has been a consistent increase in the number of people on antiretroviral therapy. At the end of 2013, 8,689 persons with advanced HIV were started on ARV treatment, representing a coverage rate of 34.8% of the 25,000 in need of ARV treatment.

Jamaica saw the first decline in AIDS deaths in 2005 and in the number of new infections in 2006. Jamaica is among four countries in the Caribbean region that has recorded declines in new HIV infections between 2005 and 2013. UNAIDS (2014) indicated a reduction of 42% in new HIV cases over the eight year period. There has also been a considerable decline in AIDS-related deaths since 2004, with Jamaica recording a 76% decline between 2005 and 2014. In terms of infection and mortality, *Jamaica is on track to meeting MDG Target 6A* ("Have halted by 2015 and begun to reverse the spread of HIV/AIDS").

Jamaica has also achieved success in reducing mother to child transmission and is on track to meeting the regional elimination goal of $\leq 2\%$ by 2015. The programme activities which are coordinated through an integrated service delivery system to ensure access to HIV testing of antenatal clients, provision of HAART to infected mothers and exposed infants and provision of alternate feeding for exposed infants have achieved a decline in transmission rate from over 10% in 2006 to 1% in 2014; and is expected to decrease even further as Jamaica scales up the implementation of labour ward testing in public and private hospitals and adopts the WHO guidelines for Options B+.

The 2013 Medium Term Review of the UN High level Targets – Jamaica Report shows progress in several indicators: increased condom use among sex workers; youth having sex later; increase in HIV testing; increased outreach among sex workers; decreased HIV prevalence among sex workers; increased testing among MSM.

Jamaica is among a select number of countries with a National HIV Policy. The Policy, first established in 2005, outlines the response to the HIV epidemic in the context of respect for, and protection and fulfilment of, all rights - human, civil, political, economic, social and cultural. It also outlines a framework for an effective multi-sectoral response to the HIV epidemic.

Since 2005, several other regulations, policies and plans relevant to HIV and AIDS have been implemented. Among the main policies are the National HIV/AIDS Workplace Policy and the Management of HIV/AIDS in Schools Policy. Further, an Occupational Safety and Health Bill is being drafted by the Ministry of Labour and Social Security. If passed, it will provide legal protection and sanctions against discrimination for people living with HIV.

There has been significant progress towards one national coordinating platform with the integration of 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 overall direction and leadership of the response currently lies with the Sexual Health Authority.

While coordination of the response lies with the Sexual Health Authority, the four regional health authorities have the responsibility of implementing programmes and services at the regional level. Further, other relevant ministries - will also continue to implement HIV response programmes.

Adolescent Sexual and Reproductive Health

Perhaps the most significant achievement to date in addressing the SRH situation of adolescents in Jamaica was the draft Cabinet Submission in 2014 of 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 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."

Other notable achievements were:

- 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 50 health care workers and other partners at a 3-day workshop. Training was conducted with 36 health care workers at five of the sites on the Standards and Criteria.
- Development, printing and dissemination of the booklet - 'Staying on Track' – A healthy lifestyle guide for adolescents 10 -14 years. The themes covered in the booklet include: Substance Use, Mental Health, Nutrition and Reproductive Health.

- Evaluation of Teen Clinic at Victoria Jubilee Hospital: An evaluation was done in 2014 to determine the impact of the services on adolescent maternal health outcomes and repeat pregnancies in the population that accessed services.

3.2 GAPS/CHALLENGES IN SRH/HIV RESPONSE

Despite the achievements of the SRH and HIV programmes in Jamaica, there are significant gaps in service delivery and in the creation of an enabling environment for realisation of SRH rights, particularly for key vulnerable populations including people living with HIV, women, adolescents, MSM and others. Many of the factors which are barriers to SRH care and provision are related to the socio-economic environment and social and cultural norms in the Jamaican society.

Additionally, the devastating impact of the HIV and AIDS epidemic has had a negative impact on the provision of reproductive health services in the country as between 2004 to the present, there was a general shift in focus by international donors from population issues to HIV and AIDS. Therefore, access to SRH services by PLHIV, youth, people with disabilities and sexual minorities has been challenging due to stigma and discrimination as well as inadequate support for the provision of SRH services to these population groups.

Below are some of the key SRH challenges.

Unmet Family Planning Needs

Data from 2008 indicates that 45% of pregnancies were unplanned (30% were mistimed and 15% were unwanted). Some 40% of Jamaican women who have been pregnant at least once, became pregnant before the age of 20 and more than 50% of young men who had fathered two or more children, reported having had children with multiple women.³³

While the percentage of women with unmet contraceptive needs has been falling steadily there is still a little over 7 percent of women whose contraceptive needs are not being met.

Despite a decline over the years, adolescent pregnancies are cause for concern: 'They put both the health of the mother and baby at risk if the mother is not physically mature enough to successfully carry the pregnancy to full term and deliver. There are also educational setbacks many adolescent females and males may have to face in order to be able to provide financially for their child. In some cases this may involve dropping out of school in order to seek income. There are also psychological factors such as stress and the inability to cope with the pregnancy which may affect young parents and, as a result may affect their child/children negatively.'³⁴

Other notable challenges include *inter alia*:

³³ Jamaica - HIV and AIDS and Sexual and Reproductive Health- CARISMA Caribbean Social Marketing Programme website [HTTP://WWW.CARISMA-PANCAP.ORG/WHERE-WE-WORK/JAMAICA?START=1](http://www.carisma-pancap.org/where-we-work/jamaica?start=1) Accessed January 25, 2015

³⁴ NFPB Background Sheet: Data on Adolescent Reproductive Health http://www.jnfpb.org/pdf/AdolescentReproductiveHealth/Background_on_Adolescent_Reproductive_Health.pdf Accessed on January 24, 2015

- Donor funds for FP have reduced significantly over the past two decades
- New protocols in contraceptive services delivery are not implemented within the Regional Health Authorities
- Contraceptive donations have significantly dwindled affecting ability to reduce stock-outs
- Maintenance of adequate peripheral inventory levels of contraceptives is not optimal
- Increasing the level of behavioural programmes among adolescents in the face of reducing resource allocation.

Another gap is the preparedness of the country to deliver SRH services in crisis, to provide a Minimum Initial Service Package for reproductive health and by developing and regularly updating contingency plans that address specific needs in crises, including natural disasters, of women, adolescents, and youth, including the survivors of sexual violence.

Maternal Health

The major challenges to maternal health include quality of care, weak surveillance and monitoring systems and human resource challenges, including a shortage of midwives and nurses, although the Ministry of Health in Jamaica maintains a policy and focus on providing skilled personnel at every birth. In addition, gestational hypertension remains the leading cause of maternal mortality across all age groups. These challenges require addressing the health and education systems and making long-term plans for sustainable change, without which Jamaica will not meet MDG 5.

In order to reduce the maternal mortality ratio:

- Public education programmes need to be developed to ensure that women and their families prepare for pregnancy and recognize the signs and symptoms of pregnancy complications in order to seek timely and appropriate care.
- Antenatal care should include health education to alert women to recognize pregnancy complications and seek appropriate and timely care. Community support is needed to ensure that these patients do not default for lack of resources to go to the hospital such as fees, taxi fare, availability of a care-giver for other children, or medical reasons e.g. too ill to travel the long distance alone.
- The primary care team must ensure that women attend referrals by giving follow-up appointments, supported by home visits where necessary.
- Jamaica needs to increase the number of skilled professionals who are appropriately trained, supervised and adequately paid. Increasing the capacity and output of nursing and midwifery schools must be supported by innovative ways to ensure their retention, once trained. A comfortable work environment, functioning equipment, available drugs and supplies and a supportive management team provide positive reinforcement and build organizational loyalty.
- Careful identification of both the causes of maternal death and underlying determinants of these deaths at the community level (knowledge of the signs of pregnancy complications, where to seek care, the importance of responding immediately and not delaying until the next clinic visit) and ensuring that mothers are compliant with referrals by monitoring adherence can help reduce maternal mortality.

- Women, their families and communities must be able to trust the formal health system to respond to their needs by providing high quality care in an efficient and culturally acceptable way where people are treated with respect, given information in a format they can understand and their autonomy is respected.
- Hospitals and health centres need to be partner-friendly, making fathers feel a welcome part of the reproductive process, integrating them early into their role as nurturers to the newest addition to the community.
- Careful review of the systemic deficiencies in quality and timeliness of care within facilities and addressing these deficiencies in a meaningful way can all contribute to reducing maternal mortality in Jamaica and ensuring achievement of MDG5. (McCaw- Binns & Lewis Bell).

Sexually Transmitted Infections

The overall STI Programme has both benefited and lost ground in the context of the HIV Programme. The HIV funding landscape shifted the focus from all STIs to HIV. This has resulted in a weakened STI programme especially with respect to leadership and management at the national and subnational levels.

There have been challenges at the service delivery level, where Contact Investigators are unable to fulfil their core duties (that of locating contacts of STI patients) due to a shortage of clinicians in the primary health care system which means that CIs had to take on the roles and responsibilities of clinicians. The NHP is in the process of reviewing and revising the STI programme – an STI technical working group is in place and an STI etiological study was commissioned in 2015.

Multiple Sexual Partnerships (MSP) and Transactional Sex

Data shows that MSP continue to be a major problem in the transmission of HIV in Jamaica. Not only are more persons reporting multiple sexual partners, but there is notable increase in the average number of partners reported among males - in 2008, males reported 5.68 partners compared to 6.2 in 2012. Whilst significant behaviour change with respect to condom use in multiple sexual partnerships has been achieved among Jamaicans over past years, this change seems to have plateaued and there is a need for new approaches, messaging and strategies to ensure increased consistent condom use and a reduction in multiple partnerships.

An increasing number of persons are involved in transactional sexual relationships; especially youth aged 15 – 24 years old. 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.

Adolescent Sexual and Reproductive Health (SRH)

Jamaica National Development Plan Vision 2030 identifies the lack of an adequate programme for addressing the sexual and reproductive health information and needs of children as a weakness in the national SRH response.

The ICPD Programme of Action acknowledges the right of adolescents and youth as rights-holders to make informed and responsible decisions about issues that affect their lives, including their sexual and reproductive health. Jamaica is party to the ICPD Programme of Action.

Dissonance between the age of consent (16 years), actual age of sexual initiation (33% of persons between 15 and 24 reported having sex before 15) and the age one can access health care without parental consent (18 years) makes it difficult to treat infected and at-risk youth.

HIV infection is on the rise among adolescents from key populations. The 2012 KABP survey and recent key population surveys provide some data on adolescent key populations in Jamaica (defined as transgender adolescents, gay and bisexual adolescent boys, adolescents who inject drugs and adolescents who sell sex). Estimates for population sizes in these groups were derived from recent behavioural surveys based on responses on the sale of sex among adolescents aged 15 – 19 years and reported male-to-male sexual behaviour. No data was available on transgender adolescents and the survey revealed no reports on injecting drug use among adolescents.

The HIV prevalence among adolescent gay and bisexual boys is estimated to be 14% while HIV prevalence in transgender adolescents is estimated to be 27% (NFPB, MSM Survey 2014).

Risky behaviours translate into poor reproductive health outcomes. Reported rates of syphilis are higher among young women than young men, but this difference may be associated with antenatal surveillance. In 2012, lifetime incidence of STIs among women aged 15 to 24 years old increased by more than 50 per cent moving from 8.2 per cent in 2004 to 14.4 per cent

Unplanned or mistimed pregnancies reflect the failure to use condoms and other forms of contraception. The fact that 18% of all births in Jamaica occur to teenagers is quite alarming. Teen-mothers often drop out of the school system, and have little support from the 'baby-fathers' in bringing up their children. This has a double negative effect – on the young mother, who has her opportunities for development truncated; and on the child, who will not receive the benefits that a better-equipped mother could provide in terms of parenting.

Data shows that there has been a decline in knowledge about HIV prevention among youth aged 15 – 24 years old from 40.2% in 2008 to 38.5% in 2012. According to the 2012 KAPB survey, 'HIV/AIDS knowledge is declining among youth- both males and females, and reflected in risky behaviour choices. This shows a worsening trend from the 2008 KABP which showed high awareness and knowledge of HIV- although these did not translate into behaviour change.'³⁵

³⁵ Hope Enterprises. 2012. Jamaica Knowledge Attitude Practice and Behaviour Survey 2012.

HIV positive adolescents, as well as adolescents and youth in institutional care (children’s homes, places of safety etc.) and juvenile centres also need access to comprehensive prevention, treatment, care and support services. Some of these young people shun engagement with the formal system. Strategies will need to be developed to increase coverage of these key populations with high quality, standardized and sustainable interventions.

Lack of Sexual and Reproductive Health (SRH) Policy and Strategy

In general, SRH programmes have developed slowly in Jamaica and this may be due to the lack of a national Sexual and Reproductive Health Policy and Strategic Plan to guide SRH actions. Programmes seldom have sustainable institutionalization and adequate outreach. As a result, SRH programmes have often failed to help women, adolescents, key population groups and PLHIV who are less able than others to exercise their rights and are more vulnerable to poor health outcomes.

Specifically, SRH programmes in Jamaica seem to have been impacted by the HIV epidemic, which saw significant funding focused on HIV and very little on other SRH components.

Limited key population reach

Key populations groups have demonstrated an intractable challenge for the HIV and SRH response and as such, the Integrated Plan must focus attention on these groups. Behaviour change interventions across these populations focusing on condom promotion, STI treatment, partner reduction and HIV testing are all necessary. However, data shows that these programmes are most effective when structural problems including economic, social and cultural issues that contribute to SRH and HIV vulnerability and transmission are also addressed.

Despite the scale up of interventions to reach key populations, it is estimated that only 30% of these populations are being reached. Sub-populations of MSM, clients of sex workers and discrete sex workers who operate in massage parlours or through the internet or telephone are not being reached (UNAIDS 2013). There are also persons within lower income, high prevalence communities, including unattached youth and persons engaged in transactional sex, who are not being reached due to poverty, violence or other factors.

Poverty

Vulnerability to HIV tends to be higher in settings where there is more poverty. Jamaica’s current rate of poverty stands at 19.9%. 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

Control over financial resources and power is fundamental to one’s capacity to access and use health information, make informed decisions about one’s health and fertility, and to negotiate and insist on safe sex practices. Conversely, when women or men are unable to make critical decisions about their reproductive and sexual health, there are high social and economic costs for them, their families, communities, and countries

Human Rights and Gender Inequalities

The existence of various pieces of legislation and policies actually increases vulnerability to HIV by limiting and/or hindering key populations, such as adolescents' ages 10-18 years, MSM, sex workers and prison inmates from accessing sexual health information, goods and services.

The Offences Against the Persons Act - sections 76, 77 and 79 - criminalizes same-sex male intercourse and as such makes the promotion and facilitation of safer sexual practices among MSM an act which goes against the law.

Additionally, there is a lack of policy/legal coherence around the age of consent and the age of majority which does not afford an enabling environment for health-care practitioners to provide care to sexually active adolescents.

Some of the barriers that limit and/or hinder access to HIV and other SRH service provision and delivery have been identified as stigma and discrimination; the lack of privacy and confidentiality; iii) limited gender sensitive and adolescent-friendly legislation and policies; and iv) limited knowledge and understanding of rights and available services. These findings were highlighted in four (4) major assessments/studies³⁶³⁷³⁸³⁹ that were completed in 2013.

Stigma associated with socially marginalised groups, especially MSM, remains very strong and acts of discrimination are common. Stigma associated with HIV remains, however the perception of stigma and discrimination associated with HIV is believed to be far more serious in the minds of PLHIV and vulnerable persons than is found in practice.

In 2013, the HIV-related discrimination redress system was reviewed and the need for redress for discrimination based on gender, sexual orientation and other related vulnerabilities beyond HIV status was highlighted. It is recommended that measurable goals and targets/milestones should be set toward the adoption of a single, general anti-discrimination legislation and the establishment of an anti-discrimination tribunal.

Gender norms about sexuality, masculinity and peer pressure may promote unprotected intercourse and contribute to acceptance of multiple partners for some young men and to a lack of voice for women in terms of when, where and with whom they have sex.

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 on heterosexual sex as a norm. Persons whose sexual orientation, gender identity and gender expression do not conform to socially sanctioned gender roles such as the Lesbian, Gay, Bisexual, and Transgender (LGBT) populations - are

³⁶ *Situational Analysis of Patient Confidentiality within the Public Healthcare Sector* by Ms Karlene McFarlane and Mrs Jennifer Stuart-Dixon (National HIV/STI Programme and Health Policy Project /USAID)

³⁷ *Review of the National HIV-related Discrimination Reporting and Redress System* by Mr Vivian Gray (HPP/USAID)

³⁸ *Legal Reforms, Social Change: HIV/AIDS, Human Rights and national development in Jamaica* by Dr Jennifer Chan (UNDP,UNAIDS, National HIV/STI Programme)

³⁹ *The People Living with HIV Stigma Index* (UNAIDS, JN+)

particularly at risk of a number of adverse HIV outcomes arising from high levels of stigma and discrimination, harassment, and sexual and physical violence

HIV Treatment, Care and Support

Despite Jamaica’s success in addressing the epidemic, HIV and AIDS still have the potential to significantly impede the social and economic development of the country and contribute to the poverty gap.

Serious challenges have persisted or are emerging in many areas. Gaps in the continuum of care persist with suboptimal linkage and retention in care, lagging ARV coverage for those in need and insufficient viral suppression levels. While poor adherence to appointment schedules and to treatment are major barriers to improving treatment outcomes, other notable barriers include stigma and discrimination, lack of adherence to protocols, poor geo-targeting of services, non-employment of new technologies, staff shortage, inadequate linkages with CSOs and the private sector.

Jamaica faces serious challenges in meeting treatment targets set by the country. The percentages shown in *Figure 6* below indicate the coverage gap or subsequent fall off at critical points along the Treatment continuum.

Of the 29,364 individuals estimated to be living with HIV infection in Jamaica, 81% have been diagnosed and reported. There are various issues surrounding testing that limit the effectiveness of the response. Routine HIV testing is still not fully implemented throughout the health system⁴⁰. There continue to be low levels of provider initiated testing in accident and emergency departments, among patients admitted to hospitals and among persons attending STI clinics in both public and private facilities. Only about 10% of hospital admissions are being tested for HIV, and even smaller percentages from family planning and other regular clinics⁴¹. Implementation of rapid HIV testing in outreach settings is also a problem in most regions. Additionally, no HIV testing facility is available on site for prison inmates. Testing is only available through visiting phlebotomists.⁴²

⁴⁰ UNAIDS. 2013. Technical Needs Assessment Report to identify bottlenecks to implementation of Jamaica’s National HIV Strategic Plan (2012 – 2017), Kingston.

⁴¹ National Strategic Plan on HIV and AIDS 2012 - 2017

⁴² UNAIDS. 2013. Technical Needs Assessment Report to identify bottlenecks to implementation of Jamaica’s National HIV Strategic Plan (2012 – 2017), Kingston.

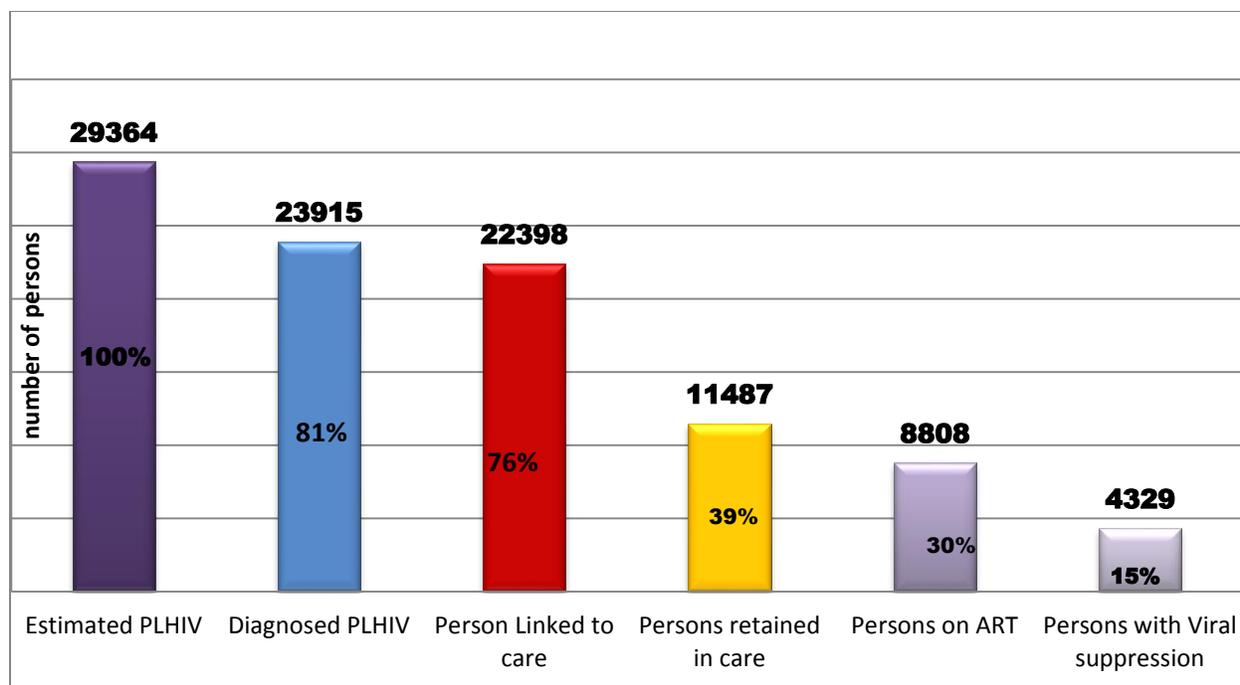


Figure 10 National HIV Treatment Cascade, Jamaica 2014

Continuing along the cascade, of those persons diagnosed, 24% have never been seen at a treatment site (i.e. linked to care); and only a little over half of those that were ever linked to care (51.2%) have been seen in the last 12 months (i.e. retained in care). A comparison of the numbers of PLHIV retained in care (4th column) and the numbers of PLHIV on ART (5th column) show very little gap which suggests that the persons who are retained in care are also primarily the PLHIV who are on ART. However, not all persons who are in need of ART (2nd column) according to WHO guidelines (i.e. $CD4 < 500$) are actively engaged in care. The persons who are in need of ART but not retained in care will include persons who have not yet been diagnosed; but also persons who may have initiated ART but have since defaulted from the clinic and their treatment.

Of those estimated to be in need of ART according to WHO guidelines, only 30% are currently on ART, of which just under half (15%) have achieved viral suppression. When taken against the total number estimated to be living with HIV, only 36.8% of those diagnosed are on ART and only 18% are virally suppressed. These falloffs at each point highlight the challenges that are being faced across the continuum of care in Jamaica, but particularly with retention in care and also adherence to treatment once placed on ART. The estimated 82% of persons who are not virally suppressed (either due to lack of engagement in care, being undiagnosed, or on ART but not suppressed) will continue to drive onward transmission of HIV.

Weaknesses in STI management resulting from the decentralization of technical leadership (UNDP 2013, UNAIDS 2013) is also seen as a major challenge.

Funding SRH/HIV Response

The classification of Jamaica as an upper middle income country by the World Bank has affected the country's ability to qualify for international aid from some sources, which has implications for the sustainability of various government programmes, including health (PIOJ, 2014).

Jamaica's major external financing arrangements have dwindled significantly - the World Bank No. 7556-JM loan expired in October 2012; Global Fund support expires in July 2015 and the PEPFAR Caribbean Regional Programme under which Jamaica receives financial support expired in February 2015. It is expected that external financing will continue to be significantly reduced over the next two years.

Given the high levels of public debt and the effects of the global financial crisis, the availability of domestic resources is constrained. Nevertheless, a substantial increase in domestic financing for the national integrated HIV/SRH response will be needed with the prospect of increasing limitations on donor funding. However the combination of high public debt levels, fiscal discipline measures being undertaken by the country, weak growth, and the impact of the global financial crisis on the local economy will prove a serious challenge for provision of domestic resources to the social sectors, including health.

In the concluding statement to its Implementation and Completion Report (2013) for Jamaica's Second HIV/AIDS Project, the World Bank pointed out the threat posed by the poor performance of the local economy: 'The current socio economic climate within the country however will continue to erode the gains and unless investments in HIV is continued at least at the same level the gains could be reversed in the medium term.'⁴³

3.3 KEY AND OTHER VULNERABLE POPULATIONS

This NISP recognises people living with HIV, women and girls, men who have sex with men, sex workers, transgender women, homeless drug users, prison inmates, persons with disabilities and the elderly as key and other vulnerable populations which will be specifically targeted. Below is a snapshot of the situation of these groups.

Women and Girls with emphasis on Girls 15-19 years

In respect of family planning, a number of issues continue to dog the integrated SRH/HIV response. Central to these is the issue of unmet need for family planning⁴⁴. Although unmet need for family planning among females 15-44 has continued to trend downward (See figure 1), high rates of unmet need persist in some parishes.

The Western region had the highest percentage of unmet need (8.7%) when compared with other regions among females 15-49 years. Notably, the parish of St. James had an unmet need of 13.6% among this age group (2008, RHS). As previously mentioned, family planning indicators (including unmet need for family planning) are impacted by several factors, including that of contraceptive security. The impact of this was clearly observed in the NFPB's most recent assessments, specifically, the Evaluation of Contraceptive Implant Utilisation in Jamaica (2014) and the Contraceptive Logistics Management Assessment Report (2013).

Priority groups include teenage mothers due to elevated rates of teenage pregnancy and high risk of repeat pregnancies within the

⁴³ HIV/AIDS Project. Document of the World Bank. September 30, 2013. A woman's need for family planning may change throughout her life. At one point in time, they may have an unmet need at a later point due to a

adolescent years. As at 2008 there were 72 live births per 1000 girls in the 15-19 age groups. Girls within the 15-19 age cohorts continue to be 4 to 5 times more vulnerable to HIV transmission than boys in the same age cohort. This is due largely to cross-generational sex and transactional sex and the impact of harmful gender norms that disempower women and girls. Emphasis must be placed on addressing the barriers that inhibit access to sexual and reproductive health information and services for young people.

Additionally, myths that give rise to greater exposure of young girls to risk continue to exist and many young women are not sufficiently empowered to insist on safe sex practices. The NFPB reports that adolescents have less access to HIV treatment and care relative to older people and even when they do get into HIV treatment programmes, their adherence to treatment regimens is typically lower compared to older adults with about one third of adolescents who do enrol in HIV care programmes dropping out. As a consequence, increased focus will need to be placed on interventions geared at to addressing the specific needs of young female PLHIV.

Men who have sex with other men (MSM)

Gay men and other men who have sex with men are disproportionately affected by HIV with an alarmingly high prevalence rate of 32%. Social vulnerability, marginalisation, social exclusion due to dominant heteronormativity and other underlying determinants continue to drive the epidemic among the MSM population. Many become homeless due to family rejection, social rejection, being ostracised from their communities, and victimization through violence, threats and abuse. This situation leads to high risk survival sex, sex work and situational sex. Those who had ever been homeless, victims of physical violence and from lower socio-economic strata were at an elevated risk of up to 48%⁴⁵.

Jamaica has had very little success in reducing HIV prevalence among MSM. Buggery remains illegal in Jamaica, and religious and other public opinion/interest groups have been extremely vocal in advocating for maintaining laws criminalizing same sex intimacy. Stigma and discrimination against MSM also hinders prevention efforts and creates barriers to accessing timely treatment care and support services. The 2012 MSM study indicates that high rates of HIV infection among MSM and bisexuality among MSM also fuels heterosexual HIV transmission. Female partners of MSM account for 7% of new HIV infections. There is urgent need to identify remedial actions and, if necessary, revise the strategy and/or implementation of activities targeting MSM in Jamaica. Peer education and outreach have been the primary methods in reaching MSM in Jamaica. This approach needs to be strengthened in order to increase access to services, coverage and ensure linkage to timely treatment care and support.

Qualitative research suggests that sexual identities and relation patterns among MSM are diverse (HIV/AIDS Risk Mapping, 2003; Culturally Sensitive HIV Interventions, 2010). MSM with higher income, power and status were perceived to be sexual decision makers. Harmful gender norms also disempower receptive partners, who were expected to play the submissive feminine role with little ability to negotiate condom use. Research participants also reported less interest in condom use with female partners because they were perceived to be less risky.

⁴⁵Weir, Figureoa op cit

There is a dearth of data on some subgroups within the MSM population such as MSM with high socioeconomic status, adolescent MSM and “non-identifying” MSM as these persons remain underground and/or are not accurately captured in surveillance systems. HIV prevention and treatment efforts have been challenged by inadequate coverage of the MSM population due to the legislative framework and a difficulty in addressing barriers faced by MSM. Given the large number of MSM who are HIV infected, the frequency of multiple partnerships and condom use patterns, the high HIV prevalence may even increase if meaningful behaviour change and universal access to HIV services are not achieved.

Transgender women

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.⁴⁶ CDC (2013) reports that transgender women, especially African-Americans, are at “high risk” for HIV infection — a warning confirmed by Baral et al. (2013): ‘physical and social violence targeted towards transgender women in particular “might be an intermediate variable in the causal pathway towards HIV infection.’⁴⁷

In Jamaica, little has been explored with regard to sexual and reproductive health needs among 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%. 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. 67.37% of transgender women reported condom use at last sex (with male partner).

The stigma attached to gender variance appears to be the overarching sociocultural barrier for transgender women. Transgender communities are often fragmented and lack visibility within the legal and policy spheres. This creates a structural barrier to social acceptance and inclusion within services as a consequence⁴⁸.

There is no surveillance data on the transgender population, which makes it difficult to design any policy or programmes targeting this invisible population. Surveillance data on the transgender population should be collected. Included in this data gathering should be violence data due to the increased levels faced by HIV+ women, and transgender persons due to stigma and discrimination.

Inmates

⁴⁶Reback 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

⁴⁷Baral, S. et al. 2013. Worldwide burden of HIV in transgender women: a systematic review and meta-analysis. *Lancet Infect Disease*; 13: 214–22. [http://dx.doi.org/10.1016/S1473-3099\(12\)70315-8](http://dx.doi.org/10.1016/S1473-3099(12)70315-8) accessed January 25, 2015.

⁴⁸Blueprint for the provision of comprehensive care for trans persons and their communities in the Caribbean and other Anglophone countries (PAHO)

The HIV prevalence among inmates in Jamaica’s correctional facilities stands at 2%. Buggery remains a criminal offence in Jamaica and this negatively impacts prevention interventions within these facilities. Interventions with new inmates, parolees and visitors including HIV testing, peer education, treatment and care for HIV positive inmates and follow up with them, subsequent to parole to ensure retention in care, will need to be scaled up to maintain prevalence at current levels or reduce the rates among this population.

Homeless drug users

HIV prevalence among this group stands at 4%⁴⁹. The group also represents a mixing of other key populations including male and female sex workers, MSM and TG and are most likely to be impacted by social vulnerability factors. While, interventions to address issues of homelessness and drug use has largely been driven by the National Council of Drug Abuse (NCDA), FBOs and other civil society partners, this has been concentrated in the Kingston Metropolitan Area and has very limited reach in other urban centres where homelessness is as pervasive.

People living with HIV

A major intervention geared towards PLHIV in recent times has been the development of a Positive Health Dignity and Prevention (PHDP) strategy to address the specific needs of PLHIV in the context of the family, community and health care settings including access to family planning services. While this has proved an important strategy to addressing the range of issues faced by the community, anecdotal evidence suggests there is need for capacity building of health care workers to implement comprehensive strategies including empowerment and social support. At the community level interventions to address issues relating to stigma and discrimination in order to create a more supportive environment for PLHIV are still lagging. Additionally, focus will need to be placed on building a peer support and navigation framework which can ensure timely linkage to care, adherence and retention in care.

Male and Female Sex Workers

There are several social and underlying determinants that continue to drive risk behaviours among sex workers. Whereas the national response has reaped some success - as evidenced by reductions in HIV prevalence among this population from 12% in the early 1990’s to 9% in 2000 and 4% in 2012⁵⁰ - male sex workers on the other hand have not been as aggressively targeted which reveals a gap in programming. Drug and alcohol use is high among this group which further increases risk and this is exacerbated by usually low literacy rates and high rates of teenage pregnancy among FSW which together increases social vulnerability and reduces access to information and services. Furthermore, sex workers are often victims of physical violence, robbery, rape, human rights violations and police

⁴⁹ Site based surveillance data

⁵⁰ Hope Enterprise, Weir etc

harassment. The 2012 sex work survey showed that just over 30% had spent at least one night in jail and 18% had slept outdoors because of homelessness.

Persons with disabilities (PWDs)

*Persons with disabilities have the same sexual and reproductive health (SRH) needs as other people.*⁵¹

It is well documented that the vulnerability of persons with disabilities, combined with a poor understanding and appreciation of their sexual and reproductive health needs, places them at higher risk of HIV infection (UNAIDS 2014). HIV-related information on persons with disabilities in Jamaica is very limited. Data on prevalence among this highly vulnerable group is not measured.

Common misperceptions affecting public health planning and people with disabilities include the belief that people with disabilities are sexually inactive and do not require HIV or sexual reproductive health services. Oftentimes, SRH for PWDs is focused on preventing disabled woman from getting pregnant, and this is sometimes imposed by family members and health professionals, without the consent of the disabled person.

The National Policy for Persons with Disabilities defines disability as:

*Any restriction or lack of ability to perform an activity in the manner or the range considered normal for a human being. Such restriction or lack of ability must be as a result of impairment*⁵².

The UN Convention on the Rights of Persons with Disabilities also notes that:

*Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.*⁵³

PWDs are often marginalised from mainstream society and often have low levels of formal education, training and certification. In October 2014, Jamaica passed the National Disabilities Act. With the enactment of the National Disabilities Act, it is important that PWDs are included in the integrated SRH/HIV strategy.

The WHO promotes five areas to bring about positive change:

1. Establish partnerships with public, private and civil society actors.
2. Promote research into the SRH situation and needs of persons with disabilities.
3. Raise awareness among the general population and health care providers on disabilities.
4. Develop policy, laws and budgets for the SRH care of persons with disabilities.
5. Reach and serve persons with disabilities with SRH provisions.

⁵¹ WHO/UNFPA guidance note Promoting Sexual and Reproductive Health for Persons with Disabilities

⁵² Vision 2030 Persons With Disabilities Draft Sector Plan 2009-2030

⁵³ Ibid

CHAPTER 4. THE INTEGRATED STRATEGY 2014-2019

Integrating sexual and reproductive health (SRH) and HIV and AIDS will require the restructuring of the health sector to deliver HIV and AIDS services within sexual and reproductive health (SRH) services or the delivery of SRH services within HIV and AIDS services, simultaneously. Restructuring to ensure the integration of HIV and SRH services will ensure a more holistic response to HIV and SRH in Jamaica.

Achievable goals and sound principles provide the foundation upon which a successful multi-sectoral, integrated SRH and HIV response can be built. The vision, goal, principles, strategic outcomes and targets which follow are derived from a broad consultative process with stakeholders as well as a range of United Nations resolutions, documents and initiatives and are viewed as prerequisite in developing and sustaining effective HIV and SRH responses. The goals, strategies, and interventions described in this five-year plan are formulated within the context of the UNAIDS (2015) vision and goals and the guiding principles promulgated in the Global Strategy Framework as well as Vision 2030- Jamaica's National Development Plan.

With the integration, the former National HIV/STI Programme (NHP) is now known as the HIV/STI Programme in the Ministry of Health.

Vision

All Jamaicans enjoying optimum health in an environment where their sexual and reproductive rights are respected, protected and fulfilled

Goal

Jamaicans are enabled to achieve high-quality, high impact, equitable and sustainable integrated sexual and reproductive health and HIV services.

Strategic Outcomes (SO)

The NISP is structured around the following six overarching strategic outcomes (SO). Each SO is comprised of several outputs, which in turn have various activities to be implemented over the five year period. A set of targets have also been established for the response over the five years:

1. Improved access to quality family planning services.
2. Reduced incidence of new HIV infections.
3. Improved access to quality treatment care and support to reduce SRH/HIV-associated deaths.
4. Strengthened policy and legal framework for sexual and reproductive health and HIV prevention, treatment and care services.
5. Strengthened multi-sectoral partnerships to effectively plan, implement, monitor and evaluate programmes within and integrated SRH/HIV framework.
6. Enhanced capacity for the provision of integrated SRH and HIV services within the health sector

SO1: Improved access to quality family planning services

Increasing contraceptive prevalence and reducing fertility rates are high priorities for Jamaica. Use of family planning methods currently stands at 72% and is below the national target of 76%. Additionally, unmet need for contraception, as defined by the expressed desire either to limit or to space births is currently at 7.2%.

The quality knowledge among men and women will be further enhanced to include knowledge of the safety, effectiveness and availability of various methods of family planning through sustainable, high-quality BCC and IEC activities.

Access to family planning services especially for adolescent girls needs improvement. To address this, various approaches will be employed over the five year period including provision of age appropriate information on SRH services and commodities to adolescents and addressing family planning-related policies which would allow access to adolescents in an open and non-judgmental manner.

Achieving improved access to family planning services will also depend on having adequate resources, skilled personnel, facilities, commodities and a supportive legal/policy environment. These will be addressed through various strategies including task shifting to increase SRH and Family Planning services; integrating the provision of family planning commodities and services into other health areas and non-health areas such as CSOs, training of health care workers to administer long acting contraceptives and the removal of social/legal barriers to accessing services.

Jamaica will develop a Comprehensive Package of Family Planning Services which will result in:

- improving contraceptive supply to meet previously unmet need;
- strengthening of partnerships in the supply and delivery of family planning products and services

It is well recognised globally, that access to family planning services is also hampered by gender-based violence. Programmes aimed at the prevention of gender-based violence services will be implemented including training of HCWs to recognise signs of violence against women and to assess and refer affected women.

SO2: Reduced incidence of new HIV infection

A key target of the NISP is to reduce by half new HIV infection by 2019. Currently, an estimated 30,313 persons are living with HIV. Whilst the national HIV prevalence stands at 1.8%, the rate among some key populations currently exceeds the national rate. Among men who have sex with men (MSM) HIV prevalence based on 2012 estimates is 32%. HIV prevalence among female sex workers (SW) is 4.2%, among prison inmates, 1.9% and among homeless drug users, the prevalence rate is estimated at 4.02% (Jamaica Country Progress Report – Global AIDS Response Progress Report 2014).

A full spectrum of preventive, diagnostic and therapeutic services for an integrated SRH and HIV programme is promoted. Behaviour Change Communication and IEC campaigns that promote information about behaviours to prevent transmission of sexually transmitted infections, including HIV and reproductive tract infections (RTIs) are key strategies utilised to prevent new infections. The concerns of key populations (MSM, TG, SW, homeless drug users, PWDS), women and adolescent girls are specifically addressed.

Recognising the importance of SRH and HIV prevention commodities, a comprehensive and integrated national programme for procurement, distribution, promotion and monitoring of SRH and HIV prevention commodities will be developed and implemented.

SO3: Improved access to quality treatment care and support to reduce SRH/HIV-associated deaths.

This strategic outcome focuses on the content and quality of services provided to PLHIV, key populations at risk, women; screening, interventions for prevention, diagnosis, and treatment of major causes of maternal or new-born morbidity and vertical transmission of HIV. It also focuses on sexually transmitted infections/reproductive tract infections (RTI) management and SRH/HIV supply chain management.

Maternal Mortality continues to be a concern with Maternal Mortality Ratio (MMR) in 2013 estimated at 108.7 per 100,000 live births. The profile indicates that 3% of deaths among women of reproductive age were due to maternal causes in that year. AIDS-related indirect deaths constituted 7.5% of all maternal deaths.⁵⁴ The NISP will support efforts by the Jamaican Government to address maternal mortality issues. This will be done through the implementation of programmes that integrate family planning and maternal new-born health (MNH). This includes the provision of a comprehensive package of FP/MNH that will address women's reproductive health needs in a gender and culturally sensitive manner. The strategy specifically addresses the important role of men in advocacy, support and planning for healthy pregnancy and births.

The NISP recognises that the survival of persons living with HIV remains the rationale for the provision of treatment, care and support services. The NISP seeks to ensure the reduction in AIDS-related deaths by providing ARVs, ART, nutrition and psycho-social and other support to address the structural drivers of HIV to persons infected by HIV.

Similarly, STIs are the third most common cause of healthy life years lost by women of reproductive age, exceeded only by maternity-related causes and HIV. Screening and treatment for syphilis is one of the main strategies that will be implemented. The provision of services related to STIs and reproductive tract infections will be routinely implemented through integration into programmes addressing maternal and child health, family planning or HIV.

The plan also addresses the needs and concerns of key populations whose SRH/HIV choices are limited by social, moral and legislative issues.

SO4: Strengthened policy and legal framework for sexual and reproductive health and HIV prevention, treatment and care services.

Vision 2030 Jamaica assures that Jamaicans are empowered to realize their social, cultural and human rights. Progress towards universal access to quality sexual and reproductive health and HIV prevention, treatment and care services and the fulfilment of sexual and reproductive rights will be dependent on removing all barriers that result in the marginalised having limited access to SRH information, goods and services.

These barriers will be addressed through a comprehensive package of services and actions within the mandates of the priority area Enabling Environment and Human Rights. Emphasis will be on developing the capacity of key stakeholders including PLHIV, key populations, CSOs to advocate and hold duty bearers accountable through rights awareness programmes and review of a range of legislation and policies to bring them in alignment with international standards.

⁵⁴ Maternal mortality in 1990-2013 WHO, UNICEF, UNFPA, The World Bank, and United Nations Population Division Maternal Mortality Estimation Inter-Agency Group Jamaica. http://www.who.int/gho/maternal_health/countries/jam.pdf?ua=1 Accessed on January 25, 2015

Strategies will also focus on addressing key barriers identified in various studies and experience with implementing interventions over the last 20 years. Among the key issues to be addressed are: stigma and discrimination, lack of privacy and confidentiality; policies and legislation and limited knowledge and understanding of rights and available services.

SO5: Strengthened multi-sectoral partnerships to effectively plan, implement, monitor and evaluate programmes within an integrated SRH/HIV framework.

A number of cross-cutting issues are deemed important to achieving outcomes one to four. The NISP emphasizes the critical importance and strategic value of multi-sectoral partnerships between the NFPB and HIV/STI/MOH; between the various stakeholders in the response; between stakeholders and NFPB/NHP and between the HIV/STI/MOH/NFPB and other government ministries, agencies and departments. Additionally, the strategy also highlights the importance of partnerships with the private sector and community-based/faith-based organisations.

The strategic plan also calls for implementation of an integrated Monitoring and Evaluation Framework. The M&E Framework will be complemented by the development and implementation of a SRH/HIV research agenda.

SO6: Enhanced capacity for the provision of integrated SRH and HIV services within the health sector

A number of barriers to the provision of an integrated SRH and HIV service exist and must be addressed. Some of these include *inter alia*, weak structure for the management of integrated services at all levels; monitoring and evaluation system need to be improved to measure SRH and HIV service integration; stigma and discrimination at the service level; uncertainty among service providers towards integration and limited staff.

This strategic outcome will include strategies aimed at building the capacity of health care workers to provide quality integrated SRH and HIV services.

4.1.1 PRIORITY AREAS

The Plan is consolidated around five priority areas aligned to the strategic outcomes. These are built around a policy and programme framework encompassing:

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
5. Sustainability, Governance and Leadership

4.1.2 MAIN TARGETS

A number of targets are expected to be achieved over the five year period. The key targets are:

1. Reduce by 10% the number of unplanned pregnancies by 2019
2. Reduce the unmet need for contraceptive among all women 15-44 years to 5.7% by 2019
3. Increase contraceptive prevalence rate to 76% by 2019
4. Increased dual method contraceptive use by 20% by 2019
5. Reduce by half, the number of new HIV infections by 2019
6. Increase coverage of ARV treatment for PLHIV to 65% by 2019
7. Increase to 90% the proportion of PLHIV on ART one year after initiating therapy
8. Reduce the number of HIV related deaths by 25% by 2019
9. Eliminate vertical transmission of HIV and syphilis by 2015

Guiding Principles

The National Strategic Integrated Plan is guided and underpinned by Vision 2030 National Development Plan; the National Strategic Plan on HIV 2012 – 2017; the Millennium Development Goals, the United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/AIDS and the International Conference on Population and Development (ICPD) Programme of Action.

The guiding principles determine the priorities, the design of the interventions, and the approach to integration. The overarching principles of protection, confidentiality, consent and human rights are applicable throughout the plan. The strategy is guided by the following broad principles:

1. **Political Leadership and Commitment:** Strong political leadership and commitment at all levels is essential for a sustained and effective integrated sexual and reproductive health and HIV response.
2. **Good Governance, Transparency and Accountability:** An effective national response to the sexual and reproductive health needs of Jamaicans and the HIV epidemic requires leadership to mobilize and manage human, financial and organizational resources in an effective, transparent and accountable manner.
3. **Address structural determinants:** The root causes of HIV and sexual and reproductive ill-health 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
4. **Equity:** Sexual and Reproductive health and HIV responses should ensure that no person is denied access to information, 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 their sexual and reproductive ill-health and how to prevent and treat this state of health 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, homeless persons, adolescents and women.

5. **Focus on human rights:** The rights of all Jamaicans regardless of age, religion, socio-economic status, gender and sexual orientation must be respected. Thus, the sexual and reproductive health and rights of men, women, boy, girl, people with disabilities, youth, adolescents, hard to reach populations, sexual minorities and other key populations must be respected. The protection, non-discrimination, non-stigmatisation of PLHIV, key populations and all other vulnerable groups is to be applied across all sexual and reproductive health and HIV programme areas. Discriminatory practices (including unequal gender relations) create and sustain conditions leading to sexual and reproductive ill-health and to inadequate treatment, care and support as well as inadequate access to services.
6. **Promote Gender Responsive Programming:** Gender equality and equity is to be applied in all programming and interventions to meet the unique needs of women, girls, men and boys. Gender sensitive policies to establish gender equality and eliminate gender-based violence are to be promoted.
7. **Promote a coordinated and coherent response:** Sexual and reproductive health priorities should be considered within a coordinated and coherent response to HIV that builds on the principles of: one national HIV and AIDS framework; one broad-based multi-sectoral HIV and AIDS coordinating body; and one country-level monitoring and evaluation system.
8. **Meaningfully promote key stakeholder participation:** The meaningful participation of women and men living with and affected by HIV and AIDS, key populations and vulnerable groups in the design, implementation, monitoring and evaluation of policies and programmes and research that affect their lives. Emphasis on youth/adolescents living with HIV, including those infected prenatally, should also be sought.
9. **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.
10. **Foster multi-sectoral approach and Partnerships:** The active involvement of all sectors of society is necessary to ensure an effective response, including effective partnerships, consultations and coordination with all stakeholders in the design, implementation, monitoring and evaluation of programmes, policies and research. Young people and key populations are essential partners for an adequate response to the described challenges and for meeting their own needs
11. **Reduce stigma and discrimination:** More vigorous legal and policy measures are urgently required to protect people living with HIV and key populations from discrimination.
12. **Recognise the centrality of sexuality and sexual health:** Sexuality and sexual health are essential elements in human life and in individual, family and community well-being.
13. **Promote the use of evidence-based decision making and programming:** Interventions are to be designed based on the specific conditions of vulnerability and risk behaviours verified to be driving sexual and reproductive ill-health. Sexual and Reproductive Health and HIV programmes should also be designed based on the relevant epidemiological, economic, social and age contexts.

CHAPTER 5. PRIORITY AREAS FOR ACTION 2015-2019

The Plan is consolidated around five priority themes aligned to the strategic outcomes highlighted above. These are built around a policy and programme framework encompassing:

1. Prevention and SRH Outreach
2. Universal Access to integrated SRH, HIV, STI Treatment, Care and Support Services
3. Enabling Environment and Human Rights
4. Monitoring and Evaluation of the HIV, Family Planning and Sexual Health Response
5. Sustainability, Governance and Leadership

Each strategic outcome has various outputs and several key actions associated with these outcomes.

The priority areas and their key strategic actions focus upon integrated sexual and reproductive health interventions through a holistic approach. This approach provides opportunities to reduce unintended pregnancy and sexually transmitted infections (STIs), including HIV; reduce maternal and new-born morbidity and mortality; reduce gender based violence and improve SRH Laboratory Facilities, reduce HIV-related deaths and improve the human rights, policy and legislative environment.

The priorities identified in this document pay particular attention to performance criteria as the basis for defining the approach and activities. These criteria include, but are not limited to:

- access
- quality
- efficiency
- financing

Additionally, particular attention will be paid to the cross-cutting impact of gender equity and multi-sectoral partnerships across all strategic performance areas and to the responsibility for monitoring and evaluation of progress towards achievement of the strategic plan.

5.1 STRATEGIC PRIORITY 1: PREVENTION AND SRH OUTREACH

The integrated HIV prevention and SRH outreach component will provide a comprehensive package of services for those most vulnerable and at elevated risk for HIV/STI transmission, unplanned pregnancies and unmet family planning needs.

Specifically, the component will also develop, promote and support health promotion and behaviour change strategies that impact sexual risk behaviours and cultural norms such as multiple partnerships in order to reduce transmission of HIV and other STIs and prevent unplanned pregnancies. The strategies will focus on reducing risk behaviours among general as well as key populations and other vulnerable populations by promoting self-efficacy and the adoption of healthy lifestyles.

Promotion of condom use, partner reduction, HIV and syphilis testing, myth rejection, building knowledge and skills and stigma reduction will remain key components of the national response. New initiatives that will be undertaken to increase reach to targeted populations are rapid HIV tests with

shorter turnaround times for results and a scaled-up peer navigation programme which will see members of the target populations being employed as major links through-out the continuum of care with alternate points of care providing complementary services to the public health system.

As most women seek sexual and reproductive health (e.g. antenatal care, family planning) and HIV services (e.g. prevention of mother-to-child HIV transmission or PMTCT) at some point in their lives, integrating violence prevention and HIV services will provide an opportunity to: identify women in danger before violence escalates; provide emergency care; prevent or reduce negative health outcomes of violence (e.g. unwanted pregnancy, STIs, HIV, trauma).

The main outcomes associated with Strategic Priority Area 1 are:

- SO1: Improved access to quality family planning services and
- SO2: Reduced incidence of new HIV infections

These are supported by 11 outputs and related actions.

Strategic Outcome 1: Improved access to quality family planning services

Output 1: Comprehensive package of Family Planning services developed **and** implemented to reduce unplanned pregnancies and address unmet family planning needs

The key actions will include advocacy for the adoption of new contraceptive methods; creating awareness and improving the quality of care and availability of family planning commodities so as to meet the demand for services. The actions will also involve building the capacity of HCWs to administer long acting contraceptive methods.

Key Actions:

- Advocate for the adoption of new contraceptive technologies and the availability of multiple methods to meet the varying needs of couples including women living with HIV and sero-discordant couples.
- Provide age appropriate and accurate information on sexual and reproductive health services and commodities for sexually active young people to prevent unplanned pregnancies and to teenage mothers to reduce repeat pregnancies.
- Provide information about available contraceptive methods to increase acceptability and uptake
- Provide parenting support to facilitate the raising of emotionally resilient children and to address SRH issues affecting young people
- Promote the greater involvement of males in family planning, including decision making on number and spacing of births
- Develop life skills programmes that address issues of puberty and relationships, the skills to negotiate sex and condom use, and gender norms that shape boys' notions of masculinity and limit girls' control over sex

- Conduct training to ensure adequate cadre of midwives, nurses and doctors equipped to administer long acting contraceptive methods such as IUCDs, implants and permanent methods such as tubal ligation and vasectomy.
- Promote task shifting to increase SRH and family planning services
- Strengthen partnerships with key stakeholders and CSOs to promote screening and treatment for diseases and illnesses relating SRH e.g. Pap smears, breast exams, prostate checks.
- Target men with information on family planning/reproductive health, HIV and AIDS, STIs

Output 2: Enabling environment for the delivery of family planning services created

Key Actions:

- Provide policies and regulatory mechanisms which will guarantee access, which is universal and equitable, to family planning information and services
- Support civil society advocacy for family planning services in underserved and marginalised communities
- Make provisions for community-based distribution of FP commodities in order to reach underserved and marginalised communities
- Support influential community leaders to champion and advocate for FP within the communities
- Enforce regulations and standards for providing quality family planning services.
- Ensure that standards for family planning service delivery are regularly monitored and updated in both the public and private health sector.

Output 3: Prevention of gender-based violence services implemented

The actions put forward will address underlying gender norms related to sexuality, masculinity and femininity which put women and girls at risk of STIs including HIV. Based on the linkage between GBV and HIV, HCWs will be trained to identify signs of violence against women and girls in the clinical setting.

Key Actions:

- Develop violence prevention programmes for the greater involvement of men and boys to support their own SRH/HIV decisions
- Develop programmes to promote gender equitable attitudes and behaviours
- Develop and implement programmes that address all forms of violence against *all women and girls*⁵⁵ in public and private spheres, including trafficking and other forms of sexual violence
- Train providers to recognize signs of violence against women and girls; to assess women's risk of violence; and provide women-centred care.

⁵⁵ This includes women and girls who identify as lesbians and transgender.

- Develop and implement protocols to identify women with signs and symptoms indicative of intimate partner violence (i.e. clinical inquiry), and provide them appropriate clinical care and referrals to support services;
- Develop advocacy programmes for women, their partners, family members and the wider community about gender equality in sexual health and HIV related decision-making; helping women who fear or experience violence increase their safety and to access support services (e.g. for legal services, shelters, women’s nongovernmental organizations, support groups);
- Develop empowerment programmes that teach women and girls partner communication and negotiation skills.
- Support community interventions on the issue of gender-based violence as a social and health condition

Output 4: Civil Society Organizations (CSOs) supported to provide integrated SRH and HIV prevention, care and support services

Civil society organisations are responsible for contributing just over 20% of SRH/HIV services in Jamaica. The strategies that will be employed will involve building the capacity of CSOs to develop appropriate, high quality prevention programmes.

Key Actions:

- Support the implementation of comprehensive prevention programmes by CSOs
- Standardize linkages to care protocols to guide the engagement of CSOs

Strategic Outcome 2: Reduced incidence of new HIV infections

Strategic Output 1: HIV/Syphilis testing among key populations and other vulnerable groups undertaken

The actions put forward will address limited HIV/Syphilis testing among key populations (MSM, SW, TG, homeless, drug user) and other vulnerable groups (PWDs, adolescents and youth). Strategies will include peer mentoring, utilising/expanding community-led testing and supporting over the counter testing.

Key Actions:

- Integrate HIV counselling and testing, and diagnosis and treatment of other STIs, into family planning services and routine antenatal care services.
- Scale up and train a cadre of peer navigators to expand reach and HIV Testing and Counselling (HTC) and Syphilis testing to key populations and other vulnerable groups
- Expand civil society-led points of care for HIV and Syphilis screening, condom distribution and other prevention services for key populations and other vulnerable groups
- Improve linkages to care for key populations and other vulnerable groups to ensure timely access to prevention, treatment and care services
- Advocate for public access and availability of over the counter (OTC) HIV testing

- Advocate for increased availability of STI screening test kits for ulcerative infections/diseases
- Adopt new HIV testing technologies to address issues of waiting time for results and reduced window period

Output 2: A comprehensive and integrated national programme for procurement, distribution and promotion of SRH and HIV prevention commodities developed and operational.

The key actions will involve developing and strengthening the procurement system to sustain an adequate supply of SRH/HIV commodities at health facilities. It will also involve building the capacity of various stakeholders to forecast the supply of family planning and HIV-related commodities to ensure adequate supplies at service sites.

Key Actions:

- Support the roll out of a logistics management framework to facilitate access to condoms and condom-compatible sexual lubricants distributed for free, ART and family planning methods
- Develop a Commodity Security Plan to strengthen links to the existing logistics system for essential drugs and family planning and HIV-related commodities, including systems for forecasting, procurement, distribution and warehousing.
- Ensure a sustained supply of commodities at strategic locations including condoms and condom compatible lubricants at PLACE and other high risk socializing venues
- Establish non-traditional condom outlets at high risk venues
- Collaborate with private sector condom distributors to facilitate condom social marketing and centralize condom and lubricant use among key populations
- Provide emergency contraceptive pills and post exposure prophylaxis to help women prevent pregnancy, in case condoms were not used or were used incorrectly.
- Strengthen private-public partnerships in the supply and delivery of family planning products and services

Output 3: Centralized peer navigation and linkage system to treatment, care and support services established

The key strategies will involve building the capacity of peers/mentors to support persons newly diagnosed and the development of protocols for linking persons to treatment and care.

Key Actions:

- Strengthen relationships between public/private facilities and CSOs to support adherence
- Develop Case management system for PLHIV, MSM, Transgender and Sex Workers to include peer support for persons newly diagnosed with HIV to ensure timely linkage, adherence to ART and retention in treatment, care and support
- Scale up PHDP-support group sessions to improve treatment literacy geared at increasing retention in care
- Train peer navigators in contact tracing, and adherence to support linkage and retention efforts at the community level

- Expand PMTCT of HIV programme to include access to other sexual and reproductive health services, including counselling on contraception, pregnancy as well as counselling and support on infant feeding options.
- Include HIV disclosure as part of the treatment protocol and expand to include safety tips for women who may be at risk of violence.
- Ensure that referral linkages are in place for care and treatment for women who have HIV-positive test results, including clinical (staging) and immunological (CD4) assessment of pregnant women, as well as provision of ARVs for eligible pregnant women.

Output 4: Prevention interventions for MSM, TG, male and female sex workers and drug users developed and implemented.

The key actions will address the high HIV prevalence among key populations. It will involve increasing access to prevention commodities, increased testing for STIs and support for the development of IEC materials for each group.

Key Actions:

- Develop and implement a comprehensive package of HIV-prevention services and interventions including HIV and STI education; access to condoms and lubricants; HIV counselling and testing; self-efficacy and life skills; clear linkage to health care, antiretroviral treatment (ART) and social services; targeted information, education and communication (IEC); and sexually transmitted infection (STI) prevention, screening and treatment. This standardized package of services and interventions will allow for the maintenance of quality and avoid duplication.
- Scale-up of peer outreach and testing of key populations by strengthening partnerships with civil society organisations.
- Train and maintain a cadre of peer navigators to address barriers to linkage and retention in care and to bridge the gaps along the treatment cascade for MSM, Transgender and FSW.
- Scale up outreach to key populations and include improved treatment literacy monitoring, promoting adherence and retention in care in the standard/enhanced package of services.
- Increase partner referral and linkages for early treatment and care.
- Provide information and education material about sexually transmitted infections tailored to the needs of each group at all health facilities in an environment free of stigma and discrimination.
- Promote the inclusion of sexual minorities in public awareness campaigns to decrease stigma and discrimination of MSM and TG.
- Increase access to appropriate family planning methods for all population groups at health facilities.

Output 5: Comprehensive package of SRH and HIV services for PWDs and the elderly developed and implemented

Key Actions:

- Lobby for policy support and initiatives to facilitate and improve the provision of disability-friendly SRH/HIV care services
- Ensure that health care facility infrastructure can respond to the needs of People with Disabilities who must access the facility, including employing health workers with disabilities
- Provide training which builds specialized skills –such as sign language – among health care providers in order to address SRH/HIV needs of PWDs effectively
- Support the revision or development of training curricula for health care providers which address the SRH needs of PWDs
- Ensure health facilities have the capacity s to provide relevant and integrated elderly-friendly services among PLHIV
- Increase access to facilities for screening, early diagnosis and treatment of reproductive organ cancers and complications associated with menopause and andropause among PLHIV.

Output 6: Integrated SRH and HIV services provided to all Jamaicans

The key strategies employed include raising awareness, engaging the community and media in SRH/HIV education and improving the quality of care for adolescents and youth and availability of commodities

Key Actions:

- Develop BCC interventions that address lack of accurate information to facilitate rejection of myths and misconceptions around SRH, Family Planning and HIV.
- Promote improved STI care-seeking behaviours to address symptom recognition and consequences of long term untreated infections
- Develop interventions that address and reshape social norms that support risky sexual behaviours and unplanned pregnancies particularly among adolescent girls
- Promote SRH/HIV education within school settings, as appropriate to the age of the student
- Provide SRH/HIV education, counselling and psychosocial services for out of school adolescents and youth
- Ensure the availability of youth-friendly services within all health facilities
- Train staff to provide quality SRH/HIV services to adolescents and youth with disabilities
- Develop protocols and guidelines for quality SRH/HIV care for young people with disabilities
- Integrate SRH/HIV and life skills programmes for youth with livelihood programmes
- Develop communication campaigns including with new and alternative media to complement and support community level interventions targeting specific HIV/STI and family planning risk factors
- Address harmful gender norms and stereotypes specifically around masculinity
- Design and implement care and treatment literacy material for PLHIV

Output 7: Structural dimensions of SRH and HIV addressed to reduce economic and social vulnerability

The strategies employed will involve partnering with key social protection agencies and government agencies that provide skills training and other social support.

Key Actions:

- Strengthen linkages with PATH to increase access to social protection for vulnerable and marginalized groups.
- Partner with Ministry of Labour and Social Security (MLSS) and Local Government-Poor Relief and FBOs and CBOs to provide shelter, care and support for homeless populations including displaced MSM.
- Strengthen SRH response within MOY/CDA/OCA/OCR to centralize programmes and interventions geared at reducing risk and vulnerability of young people and children in need of care and protection.
- Partner with relevant agencies to provide birth certificates and National identification for key populations, teenage mothers and their offspring
- Collaborate with relevant agencies including HEART Trust NTA for skills training
- Support social protection interventions including income generating projects, grants and scholarships to reduce social/economic vulnerability of MSM, TG and sex workers planning needs.

5.2 STRATEGIC PRIORITY 2: UNIVERSAL ACCESS TO INTEGRATED SRH, HIV, STI TREATMENT, CARE AND SUPPORT SERVICES

The HIV treatment, care and support programme has positively impacted the lives of PLHIV; access to HIV testing and counselling HAART and HIV care and support services have resulted in a 50% reduction in AIDS-related mortality since the introduction of ARVs in 2004 and vertical transmission of HIV has virtually been eliminated. However, there is a continuum of treatment gaps relating to: too few PLHIV being aware of their status, suboptimal linkage and retention in care, lagging ARV coverage of those in need and insufficient viral suppression levels. Currently in relation to the 90-90-90 treatment target to end AIDS, Jamaica by the numbers is 81-30-15. That is 81% of the adults living with HIV in Jamaica currently know their status. Some 30% of people living with HIV who know their status are receiving antiretroviral therapy, and 15% of them have achieved viral suppression.

UNAIDS indicates that HIV treatment is a critical tool towards ending the AIDS epidemic by 2030. To achieve this, it recommends that countries provide uninterrupted access to lifelong treatment for PLHIV, strong health and community systems, protection and promotion of human rights, and funding to support treatment programmes across the lifespan of people living with HIV.⁵⁶

The NISP will address these major gaps by improving current interventions and adopting new programmes to address stigma and discrimination at service sites; adherence to protocols and utilising

⁵⁶ Joint United Nations Programme on HIV/AIDS. 2014. 90-90-90 An ambitious treatment target to help end the AIDS epidemic.

new technologies to improve quality of care. Other strategic interventions include linkages with CSOs and the private sector.

A fully integrated range of services will be addressed to meet the sexual and reproductive health and HIV needs of all Jamaicans, including people living with HIV and key populations.

STIs are the third most common cause of healthy life years lost by women of reproductive age, exceeded only by maternity-related causes and HIV. Routine screening and treatment for STIs and RTIs will be done to reduce prevalence.

Family Planning will be fully integrated into ART services. This offers the opportunity to support the basic human right of PLHIV to achieve their reproductive intention. Assessing reproductive intentions will be a routine element of the integrated FP-ART services and will be revisited and documented periodically over the course of long-term care and treatment.

The main outcome associated with Strategic Priority Area 2 is:

- SO₃: Improved access to high-quality treatment, care and support to reduce HIV-associated deaths.

This is supported by seven outputs and related actions.

Strategic Outcome 3: Improved access to high-quality treatment, care and support to reduce SRH/HIV-associated deaths.

Output 1: HIV Testing and Counselling expanded

The key strategies will involve expanding opportunities for testing including the promotion of point of care testing and self-testing. It will also involve building the capacity of HCWs to provide non-discriminatory testing and counselling to key populations and adolescents.

Key Actions:

- Increase and promote the number of testing sites with emphasis on PITC in high yield areas and selected populations (hospital admissions, STI Clinic attendees, Ante-natal clinic attendees)
- Promote community based testing
- Adherence to/Define testing protocols for selected populations – retesting pregnant women in third trimester, test-retest strategy for MSM, sero-discordant couples
- Review and revise HIV counselling protocol in the context of the PHDP strategy to support linkage and retention in care
- Expand contact tracing programme to include CBOs
- Support self-testing methodologies in the private sector
- Train HCW to provide non-discriminatory HTC especially to key populations and adolescent girls
- Sensitize private providers about the HIV testing protocol

Output 2: Linkage and retention in care system implemented

The key strategies applied in this process will include strengthening systems to improve linkage and retention in care performance and the quality of service delivery. A major focus will be on capacity development at various levels and public/private partnerships.

Key Actions:

- Roll out the Linkage to Care Protocol with emphasis on CBO-based services
- Develop a Capacity Development Programme:
 - Training different cadres of service providers to provide care including in S&D; GBV recognition and management; adherence counselling; motivational interviewing and BCC theories
 - Assessment of Treatment facilities to identify the infrastructure requirements
 - Treatment facilities management reviewed to become more client centred and to bring it in line with legislative reforms relating to public sector working hours (flexitime)
 - Recruit peer navigators to link and retain PLHIV in care and to act as focal points for CBO referrals
- Expand Treatment sites in high density areas
- Facilitate access to HIV sensitive social protection measures such as cash transfers and nutritional support for PLHIV

Output 3: Standard Operating Procedures developed and implemented to improve quality of care

The key strategy will include building the capacity of institutions and programme implementers to carry out quality care services.

Key Actions:

- Strengthen national laboratory capacity, to support integrated SRH/HIV programmes
- Define and implement the standard package of care for all PLHIV
- Define and implement an enhanced package of care with emphasis on infected and affected children, adolescent PLHIV and key populations
- Design and implement treatment preparation protocol inclusive of job aids
- Develop and implement an HIV case management protocol
- Update ART guidelines to the latest WHO recommendations and implement on a phased basis
- Decentralize CD4 testing including point of care (POC) access
- Develop and implement standard operating procedures (SOPs) for the relationships between health facilities and CSOs in providing support for PLHIV
- Continue to expand ARV access points in the public and private sectors
- Promote patient charters and facility codes of conduct
- Provide continuous training for public and private service providers in comprehensive HIV/STI Management and Family Planning
- Develop a mentorship programme in HIV and FP care for health care providers and the affected communities.
- Integrate PLHIV with undetectable viral load in the general CNCD health care system to continue care
- Design and conduct medical audits at treatment sites
- Conduct annual HIV mortality review

- Explore and implement (where feasible) new technologies in HIV and FP care

Output 4: Effective Supply Chain Management Implemented

The key strategy will be to strengthen the logistics system to ensure an adequate supply of medicines and commodities at service delivery sites. It will also include capacity development activities for stakeholders to forecast the supply of medicines and commodities to prevent stock outs.

Key Actions:

- Review/Revise the commodity logistics forecasting systems to ensure medicines/commodities listed in the service delivery guidelines and algorithms are consistently available in the newly integrated health centres and clinics.
- Improve ARV and other treatment-related commodities procurement planning
- Continuously monitor the distribution and utilization patterns of ARV and other treatment-related commodities

Output 5: Vertical transmission of HIV and Syphilis eliminated

The key strategy will include implementing WHO Option B+ guidelines along with other actions such as integrating family planning and targeting men with the view of eliminating vertical transmission of HIV.

Key Actions:

- Implement WHO Option B+ guidelines re ART for pregnant women
- Continue current management of HEIs (ART, replacement feeding)
- Explore and implement (where feasible) new technologies in pMTCT Care
- Integrate Family Planning information and services into the pMTCT of HIV programme to address the problem of repeat unwanted pregnancies.

Output 6: Integrated STI/RTI Management Framework Established

The key actions will involve implementing services for assessment, screening and management of conditions related to the reproductive system.

Key Actions:

- Explore and implement (where feasible) new technologies in STI Care
- Integrate STI/RTI Services into FP services:
 - Assess risk for STI/RTI syndromes by asking questions and/or doing speculum and bi-manual examination.
 - Manage symptomatic women by following national syndromic management guidelines and without laboratory tests.
 - Screen for STI/RTI using laboratory tests whenever warranted and as determined by national guidelines.

- Counsel and ask about symptoms in the partner. Women with symptomatic partners should be treated, and treatment for the partner should be arranged through carefully designed strategies for partner notification
- Integrate STI/RTI services into pregnancy, childbirth and postpartum services:
 - Offer screening for other STIs/RTIs, including cervical infections, if possible
 - Manage STIs/RTIs in new-borns.
 - Give prophylaxis for ophthalmic neonatorum to all new-born babies.
- Integrate STI/RTI services into primary health care:
 - Reach population groups that are often at higher risk of STIs and who do not usually attend PHC services (especially SRH services); especially men, men who have sex with men, young people and sex workers.
 - Promote community-level and clinic-based (group or individual counselling) prevention and treatment education to ensure that STIs/RTIs awareness is raised.
 - Strengthen the referral system with facilities that are able to provide diagnostic tests when needed

Output 7: Programmes for Integrated Family Planning and Maternal New-born Health (MNH) established

To ensure that service integration is achieved at all levels, the key strategies will comprise expanding maternal new-born health to include a comprehensive package of family planning services for HIV positive women. It will also include promoting male participation in family planning and strengthening family planning services within all levels of antenatal and postnatal care.

Key Actions:

- Design and implement a comprehensive package for the delivery of an integrated FP/MNH programme.
- Expand service provision policy to include systematic offering of contraceptive services in the first year after an obstetric event regardless of the reason for the visit.
- Develop innovative strategies to encourage men/husbands/partners to participate in family planning and other reproductive health services.
- Strengthen outreach community-based models in forms appropriate for/already in use in the country for ANC, PNC, immunization and FP.
- Create new (or modify existing) information, education and communication (IEC) materials that are culturally-appropriate and understandable to all.
- Develop efficient and realistic referral system that is feasible, considering barriers such as transportation costs, distance etc.
- Strengthen antenatal and post-natal services to include information on family planning and nutrition.

5.3 STRATEGIC PRIORITY 3: ENABLING ENVIRONMENT AND HUMAN RIGHTS

The right to health is a fundamental human right. The promotion and protection of human rights inclusive of sexual and reproductive health (SRH) rights are integral to the creation of a supportive

environment for all Jamaicans to access SRH information, goods and services in a discrimination-free environment.

Stigma and discrimination toward PLHIV and their families, MSM and SW continues to adversely affect testing, uptake of HIV services, adherence to ART and access to supportive services. Stigma and discrimination associated with HIV and AIDS occurs most frequently in the community and within the health sector. As a consequence, reduction of stigma and discrimination continues to be important to HIV and AIDS prevention activities. Stigma and discrimination interventions targeting individuals, communities, institutions and seeking to establish an enabling policy and legal framework that addresses stigma effectively will be pursued. The interventions will address key drivers of HIV related stigma including lack of knowledge, fear, cultural norms and practices and increase accountability to and enforcement of human rights standards.

The enabling environment and human rights national response proposes strategies that seek to advocate for the alleviation of the barriers that increase vulnerability to HIV, other STIs, gender-based violence and unplanned pregnancies. Some of the fundamental rights to be upheld include:

- The rights of women and men to a satisfying and safe sexual life, the capability to do so and freedom to decide if and when to do so;
- The right to equality before the law, equal protection of the law and freedoms from all forms of violence, coercion and discrimination;
- The right to a comprehensive range of health services; and
- The right to privacy and confidentiality.

The main outcome associated with Strategic Priority 3 is:

- SO4: Strengthened policy and legal framework for sexual and reproductive health and HIV prevention, treatment and care services

This is supported by six outputs and related actions.

Strategic Outcome 4: Strengthened policy and legal framework for sexual and reproductive health and HIV prevention, treatment and care services.

Output 1: Policy and legislative barriers to sexual and reproductive health information, goods and services addressed.

The key strategy will involve implementing evidence-based advocacy and policy dialogues around policy and legislative changes that impede access to integrated SRH and HIV services.

Key Actions:

Support will be provided to:

- Review existing laws and policies and make recommendations for amendments in line with the 2013 legal assessment⁵⁷

⁵⁷ Some of the existing laws and policies for review include the Child Care and Protection Act and Sexual Offences Act and Management of HIV/AIDS in Schools Policy.

- Develop new laws, policies and protocols which promote a rights-based approach to service delivery
- Legislative/regulatory framework amended as needed to increase the level of participation by specific groups of women and men including key populations such as adolescents, MSM, SWs and PLHIV in health care delivery
- Develop Advocacy Strategy to:
 - Promote gender equality and protect human rights.
 - Address SRH provisions especially targeting adolescents, young people, males, PLHIV and people with disability
 - Promote SRH provisions already existing in the legislative and policy framework^{58 59}
 - Increase awareness among key stakeholders on the governments' responsibility to translate regional and international obligations and commitments into laws and policies
- Establish partnership with ministries and agencies responsible for the specific laws and policies being reviewed

Output 2: Human Rights and Policy Monitoring by CSOs undertaken

The key strategy will include building the capacity of civil society organisations in legislative, policy and service monitoring. It will also involve continued policy dialogue to engage CSOs to ensure sustained rights based service provision delivery.

Key Actions:

- Capacity Development Programme to include:
 - Training of marginalised persons, including key populations and PLHIVs to lead programmes and interventions geared toward addressing and improving their social and legal status.
 - Training CSO in advocacy on sexual and reproductive health and rights
 - Training key populations and PLHIVs in paralegal skills
 - Training motivational interviewing⁶⁰ and emotional intelligence⁶¹
 - Training of CSO in legislative, policy and service provision monitoring
 - Development and implementation of a curriculum on human rights education including legal literacy
 - Improving CSOs' skills in effectively communicating their roles and responsibilities in advocating the fulfilment of rights of all Jamaicans (especially vulnerable and marginalized)
- Implement FBO-led anti-stigma and discrimination interventions implemented and supported
- Develop and support fora, partnerships and networks among and between organizations to
 - share lessons learnt and best practices
 - strengthen coordination to reduce duplication and maximize impact

⁵⁸ Circumstances where the procurement of abortion is permissible and health services on family planning

⁵⁹ Integration, Diversion and Diversity Policy

⁶⁰ Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. Compared with nondirective counselling, it is more focused and goal-directed. The examination and resolution of ambivalence is its central purpose, and the counselor is intentionally directive in pursuing this goal.

⁶¹ Emotional intelligence is the ability to identify and manage your own emotions and the emotions of others.

- facilitate dialogue between duty bearers and rights holders

Output 3: Non-discriminatory health services provided to all, particularly youth, women and key populations

The actions associated with this output will involve continued policy dialogue to engage health care workers, programme implementers, and policymakers to ensure all Jamaicans have access to health care that is free from discrimination. It will also involve the sustained assessment of the implementation of protocols and guidelines within the health sector and building the capacity of health care workers to provide non-discriminatory care services.

Key Actions:

- On-going assessment and implementation of policies, practices and systems⁶² using a rights based approach to service provision and delivery at health facilities
- Development, implementation and monitoring of policies and protocols to support adolescents and youth living with HIV
- Promote the enactment of the Data Protection Act to address barriers to accessing services such as confidentiality and data protection within the health system
- Promote rights-based approach in the development and implementation of the patient charter and facility code of conduct
- Conduct ongoing HIV and anti-discrimination training among healthcare workers and other professionals
- Population/gender sensitive services available at all health facilities
- Monitor the implementation of protocols to guide partnership agreements between health facilities and CSOs on linkage, adherence and retention
- MOH and RHAs customer service policy and complaint mechanism established and implemented
- Communication strategy to increase awareness on the right to non-discriminatory health services (Health for All) developed and implemented

Output 4: A comprehensive framework for promoting redress established and upheld by duty bearers.

These actions involve the establishment of redress system to ensure sustained service delivery is guided by human rights and gender equality standards.

Key Actions:

- Support the MOJ in its establishment of a National Human Rights Institution
 - Strengthen the networking of entities to collect and submit reports
- Strengthen partnerships with public, private and informal mechanisms providing redress and mediation services developed and implementation guided by human rights and gender equality standards.
- Implement sensitization sessions to raise awareness about the applicability of claims about human rights among judges, lawyers and police .

⁶² Included in this would be Ministry of Health's Release of Client Information Policy Manual—and other protocols and guidelines on the management of SH including HIV.

- Develop and implement a communication strategy to increase awareness about the redress framework.

Output 5: Legal and policy environment for effective implementation of adolescent and youth reproductive health programmes addressed.

Key Actions

- Advocate for a decision on Cabinet submission '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'.
- Advocate for the elimination of social, moral and legal barriers that limit access to sexual and reproductive health information, counselling and services for adolescents and youth
- Mainstream ASRH issues into relevant national and sectoral development plans

Output 6: Framework for mainstreaming gender and reproductive rights established

Key Actions

1. Promote gender mainstreaming in reproductive health service delivery
2. Regularly review laws and policies in order to ensure that they facilitate universal and equitable access to reproductive and sexual health education, information and services
3. Engage communities to change negative norms and practices affecting sexual and reproductive health and rights
4. Build the capacity of service providers in the provision of counselling services on various problems associated with sexuality including sexual orientation and dysfunction.

5.4 STRATEGIC PRIORITY 4: MONITORING AND EVALUATION

Quality integrated SRH/HIV services are critical in ensuring continuity in use of the services. Quality service is directly addressed in the strategic plan through the development and maintenance of an integrated monitoring and evaluation system.

The Jamaica National Integrated Monitoring & Evaluation System is organized around 12 essential components of a functional M&E systems (UNAIDS). These 12 components all need to be present and work to an acceptable standard for the national M&E system to function effectively and the strategic outcomes, outputs and key actions have been developed around these.

Apart from monitoring progress in NSP implementation, the framework will provide for ongoing monitoring of the changing dynamics of FP, HIV and RH. The key strategies will include adapting the current M&E Framework to enable the tracking of integrated services, using M&E data and information for building a knowledge base, and fostering knowledge sharing among key stakeholders for priority setting.

Monitoring and evaluation of the multi-sectoral response will require greater co-ordination of all sectors (public, private, civil society and development partners) to ensure optimal utilisation of the available resources and continuous learning through sharing of experiences. The M&E Unit in the MOH has responsibility for the co-ordination of the monitoring and evaluation framework of the multi-

sectoral response at the national level. The M&E and Research unit in the NFPB is responsible for the coordination of M&E activities for HIV and Family Planning prevention, outreach, and enabling environment and human rights components of the national programme, and provides data to the MoH as part of the One M&E System. These two co-ordinating structures will oversee capacity development, data quality assurance, resource mobilisation for M&E, reporting and data archiving.

The main outcome associated with Strategic Priority 3 is:

- SO5: Strengthened multi-sectoral partnerships to effectively plan, implement, monitor and evaluate programmes within an integrated SRH/HIV framework.

This is supported by three outputs and related actions.

Output 1: Enhanced technical capacity for data collection and data use in SRH (family planning) and HIV

Key Actions:

- Strengthen partnerships for coordination and management of the M&E System
- Train relevant civil society and health sector professionals in data collection and analysis
- Support opportunities for networking and sharing among M&E, research and policy development professionals
- Support the development of organizational structures with HIV & FP M&E Functions
 - Work with stakeholders to strengthen M&E organizational structures at sub-national levels, including CSOs by reviewing MOUs and TORs for clearly defined M&E roles and functions.
- National, multi-sectoral integrated M&E Plan developed.
 - Develop a detailed integrated M&E operational plan to accompany the NISP as a follow-on document. This will detail the logical framework for each priority area, data collection tools aligned to NISP activities, data flow and data management systems clearly outlined
 - Develop Annual, Costed M&E Work Plan

Output 2: Robust mechanisms for collection, verification and analysis of integrated SRH and HIV data/information established and operational

Key Actions:

- Strengthen Routine HIV and SRH monitoring, evaluation and reporting
- Implement routine Surveys and Surveillance including of SRH and HIV interventions
- Strengthen National and Sub-national HIV and FP databases
- Implement Supportive Supervision and Data Auditing
- Establish a data audit system to ensure that routine programme data are meeting the minimum data quality requirements
- Develop Logistics information system for commodity management
- Build capacity in forecasting, standardised record keeping and stock management

Output 3: Evidence-based research to inform integrated SRH/HIV planning and programming undertaken

The main strategy will include promoting the use of research results to influence policy and programming.

Key Actions:

- Information and Data Dissemination Plan implemented.
 - National Sexual and Reproductive Health Conference and Sexual and Reproductive Health Research Day
 - Develop sharing mechanism - like a mailing list for SALISES, CARPHA, PANCAP etc
 - Quarterly M&E Newsletters
 - Provide a progress report on selected core indicators on a quarterly basis. These progress reports will be shared to HIV/STI/MOH/NFPB and with the institutions providing the data as feedback.
 - Coordinate midterm evaluation that focuses on achievements, challenges, emerging issues and recommendations for the remaining half of the NISP

Operational research, documentation, and dissemination to inform the SRH and HIV integration process are in line with national priorities.

- Develop and implement HIV and FP Evaluation and Research Agenda for both family planning and HIV, guided by an integrated MERG
- Implement operations research to assess the efficiency and effectiveness of health systems and programmes
- Support the development of innovative research protocols to increase understanding of risk factors and accelerate progress towards targets
- Facilitate relevant research in key areas of the SRH and HIV linkages to address:
 - i. linked services targeting men and boys
 - ii. gender-based violence prevention
 - iii. stigma and discrimination
 - iv. comprehensive SRH services for people living with HIV, including addressing unintended pregnancies and planning for safe, desired pregnancies.
- Develop and implement research agenda for SRH and HIV integration guided by an integrated MERG

5.5 PRIORITY 5: SUSTAINABILITY, GOVERNANCE AND LEADERSHIP

Sustaining the gains made in SRH and HIV response over the last decade has emerged as an urgent national imperative and the Government of Jamaica has committed to pursuing all measures necessary to consolidate the solid gains of the past. A major initiative towards sustainability is the establishment of an authority which joins the National Family Planning Board with parts of the former National HIV/STI Programme to lower administrative costs while strategically identifying opportunities to lower the prices of antiretroviral medicine and maximize the leverage provided by integrating SRH and HIV through reducing the frequency and cost of health related appointments. Additionally, the country has re-focused key elements of its National Strategic Plan to increase emphasis on the needs of key populations at higher risk of infection, including men who have sex with men, sex workers, sexually active young persons and people who use drugs.

In March 2013, the Government of Jamaica approved the establishment of a National Authority for Sexual and Reproductive Health that will integrate the management and service delivery components

of the former NHP and the National Family Planning Board (NFPB) thereby creating synergy, efficiency and effectiveness. This decision fulfils one of the planned strategic actions of Vision 2030 Jamaica to expand and improve integration of family planning, maternal and child health, sexual and reproductive health and HIV into primary health care. It also supports the UN Political Declaration of Commitment on HIV and AIDS (2011) that advocates linking sexual and reproductive health and the HIV response as a gateway to strengthening both the human rights agenda and health systems.⁶³ It was noted that “Human rights and the right to health were at the core of greater integration of services. A broader human rights agenda can also be promoted that goes beyond service delivery and tackles legal reforms, such as those relating to the right to information and freedom from violence, abuse and coercion.”⁶⁴

Additionally, civil society organizations in Jamaica have demonstrated limited capacity in generating financial resources working independently. However, their contribution to the HIV/STI/MOH and Family Planning in the areas of community mobilization, community research, social protection and accessing vulnerable groups has been invaluable and there is a new thrust towards increasing financial support via CSOs to maximize efficiencies and engage key population groups. Civil society organizations now provide 22.4% of all HIV-related services in Jamaica.

A formal approach to task shifting will be undertaken. Task sharing – or task shifting as it is sometimes called – is a process in which specific clinical tasks are shared at more levels. Where appropriate, tasks that are normally performed solely by certain cadres of health workers are also undertaken by other groups of health workers who may have less training and fewer qualifications.

Task sharing can be a viable solution to increasing access to sexual and reproductive health services for all people, particularly those who are poor, marginalized, socially excluded and under-served; it is a promising strategy for improving cost effectiveness within health systems. It also ensures that sufficient skills are available in the expanded service delivery as a result of integration of SRH and HIV programmes and guarantees that skills are not lost when staff are replaced or rotated in roles.

The World Health Organization has acknowledged that attempts to optimize the potential of the existing health workforce are crucial to achieve optimal and universal health coverage. It has therefore introduced global recommendations and guidelines for task shifting which define conditions and systems required for its safe, efficient, equitable and sustainable implementation.

According to IPPF (IPPF Medical Bulletin, January 2013), general recommendations to implement a task sharing initiative include:

- Regulatory frameworks in order to assess existing regulations to identify opportunities and obstacles to implement task sharing; for example, regulations that establish medical liability in cases where complications arise; and other regulations. In this regard it is important to advocate for less restrictive regulations to enable different groups of skilled health workers to practise an extended scope of work.

⁶³ UNAIDS. 2011. It's possible: Making the most of linking sexual and reproductive health and HIV responses. <http://www.unaids.org/en/resources/presscentre/featurestories/2011/june/20110609csr>. Accessed April 10, 2015.

⁶⁴ Ibid

- Programme planning that undertakes human resource analyses to identify inadequate service provision, the extent to which task sharing is already taking place, and the existing human resource quality assurance mechanisms. Engagement in stakeholder consultations right from the outset to facilitate an understanding and the adoption of task sharing is important. It is critical to involve health workers in the discussion about roles and competencies, changes in workload, and incentives to expand the scope of work or to share tasks with other groups of health workers. Communities and individual clients may also play an important role in ensuring that task sharing initiatives are implemented successfully. Task sharing should be implemented in alignment with other efforts, such as timely remuneration and public recognition of contributions, to maintain an effective, productive and motivated workforce.
- Training that ensures that providers acquire and expand the skills and competencies required to perform their duties through pre-service and in-service training and are provided with supportive supervision and clinical mentoring.
- Quality assurance measures are important to define the roles and the associated competency standards required for all groups of health workers participating in task sharing initiatives. These standards should form the basis to establish criteria for recruitment, training and performance evaluation. Formal quality assurance mechanisms to support, monitor and evaluate the task sharing approach will be required including the quality of services such as counselling and care, complication rates, client satisfaction, and others.
- Sustainability measures such as the appropriate costing and financing of task sharing initiatives are vital. Resources need to be allocated to ensure continuous training, supportive supervision and quality assurance, and to provide incentives to health workers who take on new and increased responsibilities. It will also be necessary to ensure that all groups of health providers have continuous access to the commodities and supplies required to perform the tasks assigned to them.

Tasks can be shared among different groups of health workers, such as: physician clinicians; nurse practitioners; nurses; midwives; community health workers; and pharmacists.

The priority area on Sustainability, Governance and Leadership falls under SO6: Enhanced capacity to provide integrated RH and HIV services at all levels

There are two associated outputs with key actions for implementation.

Output 1: Effective coordinated system to manage the integrated SRH/HIV framework in place.

The key strategy will include building the capacity of HCWs and programme implementers to offer quality SRH and HIV services.

Key Actions:

- Promote and support task shifting of human resources within the health sector to maximize efficiencies and reduce costs (e.g. use of peer navigators and CSO staff to support adherence and family planning counselling)

- Conduct training for service providers to provide high-quality integrated SRH and HIV services at all levels.
- Facilitate inter-sectoral collaboration with relevant agencies/institutions and sectors to impact policies and programmes related to the structural determinants that impact on HIV and adverse family planning and sexual health outcomes;
- Create delivery models with the fewest barriers for people to access services through co-locating interventions and cross-training providers
- Support integration of key population and HIV/SRH specific pre-service training in health education institutions (ERTU)
- Institute mechanisms for the participation of adolescents and youth in service delivery especially prevention and support services (i.e. capacity building in monitoring and evaluation, proposal writing, planning and designing high-impact interventions)
- Provide relevant information, education, and communication (IEC) materials and teaching tools to support healthcare workers in the provision of integrated SRH and HIV services
- Assess healthcare facilities in order to identify infrastructure requirements and supply needs for providing integrated SRH and HIV services.
- Ensure that the infrastructure of health care facilities support integrated SRH and HIV services at all levels.
- Put institutional mechanisms in place for users of health and other services related to HIV and SRH so that they can demand accountability and transparency from service providers

Output 2: Resources are mobilised and available for the effective and sustainable provision of integrated SRH and HIV services

The key strategy will involve the implementation of a mechanism to assess the costs of integrating SRH and HIV services and continued advocacy for sustainable resource mobilisation across all sectors for SRH/HIV activities.

Key Actions:

- Mechanisms for coordination of donor support to stakeholders in the HIV and SRH response established and implemented.
- Mechanism for sustainable resource mobilisation in place SRH/HIV is integrated into development initiatives, including gender programmes to achieve synergies and cost-effectiveness.⁶⁵
- Capacitate the National Health Fund to serve as a viable financing option through Statutory and other administrative measures to support the implementation of the integrated SRH/HIV response.
- Strengthen partnership with civil society through joint resource mobilization, expanding service delivery functions at the community level and community empowerment.

⁶⁵ This integration will extend beyond the Ministry of Health to include all other Government Ministries notably Finance and Planning, Education and Culture, Labour and Social Security, National Security, Local Government and Community Development, Tourism and Entertainment, Youth and Culture and their affiliate statutory bodies.

CHAPTER 6. IMPLEMENTATION FRAMEWORK

6.1 MANAGEMENT AND COORDINATION

A strong and well-defined coordination and management mechanism has been put in place to effectively and efficiently guide the integrated SRH and HIV response.

The Government of Jamaica through the National Family Planning Board and the National HIV/STI Programme will implement the NISP in partnership with civil society, including the private sector, NGOs, CBOs, FBOs and other stakeholders. In addition to this multi-sectoral approach, the implementation of the strategy will be participatory, as 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 strategy.

Strengthening and sustaining partnerships between the Government and all relevant stakeholders is critical to the success of the NISP.

6.2 INSTITUTIONAL ARRANGEMENTS

The effective implementation of this strategy 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. 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.

Implementation of the NISP will be jointly led by the NFPB and the HIV/STI Programme in the Ministry of Health through a SRH and HIV Integration at Service Delivery Level Steering Committee. The main role of the committee will be to oversee the effective implementation of the NISP at the service delivery level.

Other coordinating structures include the Regional Health Authorities (RHA) which operate under the umbrella of the Ministry of Health and the Parish AIDS Associations which coordinate the response at the parish levels. Both entities will operate through service level agreements with the NFPB.

Monitoring and Evaluation of the NISP will be carried out by the M&E Unit in the MOH. The Unit will be responsible for the co-ordination of the monitoring and evaluation framework of the multi-sectoral response at the national level. The M&E and Research unit in the NFPB will be responsible for the

coordination of M&E activities for HIV and Family Planning prevention, outreach, and enabling environment and human rights components of the national programme, and provides data to the MOH as part of the One M&E System. These two co-ordinating structures will oversee capacity development, data quality assurance, resource mobilisation for M&E, reporting and data archiving.

The Monitoring and Evaluation (M&E) system consists of various inter-related components which provide data from special surveys and programme monitoring. These data inform specific indicators which are further itemized in the national M&E plan that will guide programme managers and various stakeholders on the progress and impact of interventions being conducted. The information will be disseminated through various publications and reports on a regular basis. The M&E system benefits every contributor by providing information on various levels to improve programmes and policies around HIV.

INSTITUTIONAL FRAMEWORK MATRIX

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

INSTITUTIONS	ROLES AND RESPONSIBILITIES
Ministries, Departments and Agencies (MDAs)	
As the largest employer, the government also has a responsibility to provide and increase access to an integrated SRH and HIV services and to set up structures and systems to reduce SRH and 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 integrated strategy. - 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 strategy. - 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 NISP.

National Sexual Health Authority (National Family Planning Board)

- Promote public awareness and acceptance of the NISP
- Coordinate the implementation of SRH and HIV integrated programmes
- Support and facilitate resource mobilization activities for the NISP
- Monitor and evaluate the implementation of SRH and HIV integrated programmes
- Provide technical assistance in the integration process including quality assurance and control
- Prepare policy briefs for various policy makers
- Develop/review training curricula and implement training of HCWs.
- Guide the implementation of the NISP among CSOs
- Ensure the development of a national database of integrated SRH/HIV related programmes and facilitate dissemination of best practices.
- Put in place mechanisms for the development and periodic review of a database of key stakeholders in the national response.
- Ensure the participation of all stakeholders, PLHIV and key population groups through dialogues, consultations and information dissemination.
- Publish and disseminate guidelines for the implementation of a rights-based approach to an integrated SRH/HIV response.
- Examine any law, policies and or strategies which are likely to negatively impact the SRH/HIV response and prevent individuals from claiming their human rights.

SRH and HIV Integration at Service Delivery Level Steering Committee

- Ensure that the implementation of SRH and HIV integrated programmes are well coordinated
- Monitor and evaluate the implementation of SRH and HIV integrated programmes
- Support implementation among civil society organisations
- Participate in SRH and HIV resource mobilization activities

Regional Health Authorities

- Translate the NISP into region-specific strategies and activities;
- Build capacity of staff in SRH/HIV programme planning and implementation;
- Monitor and evaluate regional programmes for their impact
- Commit adequate resources for implementation of SRH/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 SRH/HIV and related issues.

Ministry of Education

- Translate the NISP into ministry-specific activities
- 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 teachers are properly trained, qualified and adequately resourced to teach comprehensive SRH information.
- Develop and adopt appropriate SRH/HIV course content, scope and methodology at the Teachers' Colleges.
- Monitor and evaluate MoE programmes for their impact on the national response.

	<ul style="list-style-type: none"> - Commit adequate resources for implementation of SRH/HIV-related activities; - Collaborate with the MoH, civil society and the private sector on HIV and SRH matters.
Ministry of Youth	<ul style="list-style-type: none"> - The MoY is mandated to lead the national SRH/HIV response among youth and youth organisations. - Translate the NISP into ministry-specific activities - Ensure that youth have access to youth-friendly SRH/HIV information, services and commodities - 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 SRH/HIV information and education. <p>Commit adequate resources for implementation of SRH/HIV-related activities</p>
Ministry of Finance and Planning	<ul style="list-style-type: none"> - Provide financial oversight of the national integrated response. - Ensure that grant and loan funds for the SRH/HIV response are given priority in the budget and warrant process. - Ensure that growth and investment plans include SRH/HIV related issues - Ensure that HIV and AIDS, SRH programmes are mainstreamed in the sector budget and ensure adequate and timely releases of government commitment towards implementation of the NISP. - 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)	<p>The MLSS is responsible for workplace and social protection issues.</p> <ul style="list-style-type: none"> - 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	<ul style="list-style-type: none"> - 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)	<ul style="list-style-type: none"> - Translate the NISP into ministry-specific activities - Conduct human rights training to all security personnel - Integrate SRH/HIV information and education into the police staff training curriculum - Train police to address 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 SRH/HIV-related activities
Ministry of Justice	<ul style="list-style-type: none"> - Provide guidance in the review and amendment of legislation related to SRH and HIV - 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)	<ul style="list-style-type: none"> - Develop and implement strategies, policies and programmes that respect, protect and fulfil the human rights of women and girls. - Mainstream SRH and HIV into gender-related strategies and interventions. - Develop and implement programmes and activities around gender-based violence. - Provide guidance for gender-sensitive and gender-responsive SRH/HIV programmes and activities
Parliament	<ul style="list-style-type: none"> - Provide legislation for new areas and the reform of existing laws to facilitate the implementation of this NISP - 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	<ul style="list-style-type: none"> - 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
Private Sector	<ul style="list-style-type: none"> - The Private Sector should locate SRH and HIV issues within its corporate and operational agenda

- Establish and sustain SRH/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;
-

Persons Living with HIV

- The NISP is grounded in the principle of the involvement of People Living with HIV (PLHIV) at all levels from design to evaluation. As such, PLHIV are expected to participate effectively in the achievement of the goals of the NISP. Priority roles include:
 - ✓ Input into programme design, implementation and evaluation
 - ✓ Participation in Behaviour Change Communication Activities
 - ✓ Advocacy , specifically around the Positive Health Dignity Programme and the Redress System
 - ✓ Participation in research
 - ✓ Resource mobilisation

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.

Universities and Other Tertiary Institutions

- Conduct research and collect data on SRH and HIV-related issues
- Mainstream integrated SRH/HIV education within the University system. This includes pre-service training at medical and nursing schools
- Participate in the oversight of the implementation of the NISP through the SRH and HIV Integration Steering Committee.
- Provide advice, extension and consultancy services on issues which are relevant to SRH and HIV.
- Address stigma and discrimination through stigma reduction programmes on the various campuses.
-

Churches and Faith based Organisations

- Provide care and support services including risk assessment
- Assist in dispelling myths about HIV and other SRH issues such as infertility and encouraging behaviour change
- Promoting accepting attitude and behaviour towards persons with HIV and AIDS and key populations.
- Integrate messages and information about SRH and HIV prevention, care and support into their on-going 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 NISP. National international development partners and organisations involved in SRH and HIV interventions in the country shall align with the NISP.
- Establish appropriate donor co-ordination mechanisms for ensuring responsiveness and harmonisation of development activities under the NISP.

Media

- The media is important in advocacy and increased visibility for SRH/HIV issues.
- Media entities should be part of the workplace and business sector response in institutionalising SRH and 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 SRH, HIV and human rights issues and avoid reinforcing negative stereotypes or sensationalism over SRH/HIV-related issues in reporting and advertising.
- Training and education of media personnel should become an integral part of media practice.

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ANNEXES

ANNEX 1: STANDARD PACKAGE OF CARE (HIV TREATMENT, CARE AND SUPPORT)

Psychological assessment

- ✓ Social Assessment
- ✓ GBV screening
- ✓ Food security
- ✓ Financial security

Prevention assessment

- ✓ Assessment of sexual activity, provision of condoms (and lubricant) and risk reduction counselling (if indicated)
- ✓ Assessment of partner status and provision of partner testing or referral
- ✓ Assessment for STIs and (if indicated) provision of or referral for STI/partner treatment
- ✓ Assessment of family planning needs and (if indicated) provision of contraception or safer pregnancy counselling or referral
- ✓ Assessment of adherence and (if indicated) support or referral
- ✓ Assessment of need and (if indicated) refer or enrol PLHIV in community-based programs

Medical management

- ✓ medical, psychological and social history and examination (cervical/anal examination)
- ✓ baseline investigations and (as indicated) additional investigations
- ✓ HIVDR testing as indicated
- ✓ OI screening/prophylaxis/management
- ✓ ART in the context of treatment readiness:
 - PLHIV with CD4 <500
 - Sero-discordant couples
 - Children < 5
 - continue ART post-delivery for pregnant women
 - ✓ assessment for adverse events
 - ✓ referral for specialist management as indicated

Enhanced Package of Care

In addition to the above items, the Enhanced Package of Care includes:

Adolescent PLHIV/OVC/PLHIV pregnant women/MSM/CSW

- ✓ routine enrolment in psychological care

Sero-discordant couples

- ✓ support pre-exposure prophylaxis in the private sector

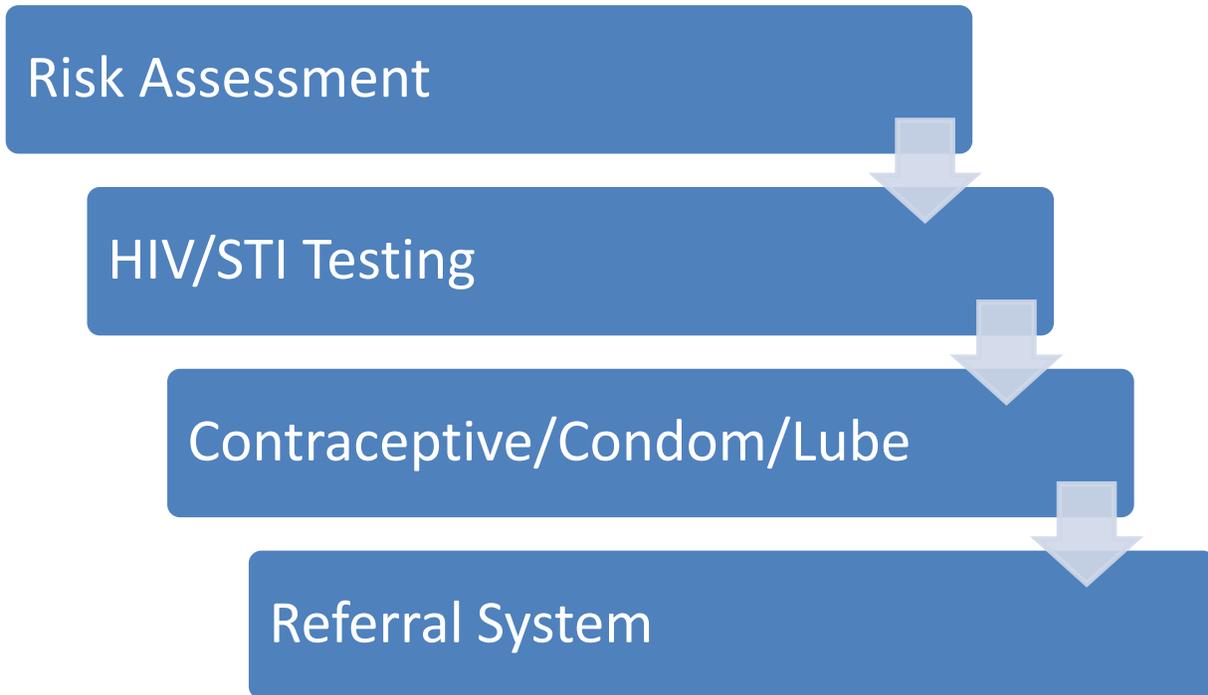
Adolescents

- ✓ establish adolescent clinics

HIV/TB

- ✓ IPT in congregate settings

ANNEX 2: COMPREHENSIVE PACKAGE OF CARE FOR PREVENTION



ANNEX 3: ALIGNMENT WITH INTERNATIONAL COMMITMENTS (SELECT)

International Conference on Population and Development (ICPD) Programme of Action (2014)

International and national policies and strategies for addressing sexual and reproductive health issues reflect the International Conference on Population and Development (ICPD) Programme of Action. The Programme of Action seeks to ensure SRH and rights for all as a critical contribution to sustainable development.

Reproductive health impacts everyone from pre-conception through childhood, through the reproductive years and beyond. SRH is impacted by people's economic circumstances, education, employment, living conditions, family environment, social and gender relationships, and legal environment within which they survive.

The ICPD Programme of Action describes RH as a holistic concept:

Reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. – ICPD Programme of Action, paragraph 7.2.

Further the ICPD Programme of Action included sexual health as, “*the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.*”

The ICPD Programme of Action recognized that reproductive health and rights, along with women's empowerment and gender equality, are important for the realisation of individual health and well-being, sexual and reproductive health, and population and development programmes⁶⁶.

Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government- and community-supported policies and programs in the area of reproductive health, including family planning. - ICPD Program of Action, para 7.3

In 2004, the World Health Organisation at the World Health Assembly adopted a reproductive health strategy to accelerate progress towards the attainment of international development goals and targets.

⁶⁶ World Health Organisation. 2014. Ensuring human rights in the provision of contraceptive information and services. Guidance and Recommendations. Geneva, Switzerland.

The reproductive health strategy states that “in order to ensure that these rights are respected, policies, programmes and interventions must promote gender equality, give priority to poor and underserved populations and population groups, especially adolescents, and provide special support to those countries that bear the largest burden of reproductive and sexual ill-health”⁶⁷.

The Glion Call to Action on Family Planning and HIV/AIDS in Women and Children (2004)

The Glion Call to Action reflects the consensus of the first consultation in May 2004 which focused on the linkage between family planning and prevention of mother-to-child HIV transmission. The call is set within the context of the objectives and actions agreed to at the Cairo International Conference on Population and Development⁶⁸. It emphasises the importance of strengthening the linkages between sexual and reproductive health and HIV/AIDS in order to achieve internationally agreed development goals.

Sustainable Development Goals

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.’** This goal lays out nine substantive targets to be reached, including:
 - 3.1: By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births
 - 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
 - 3.7: By 2030, 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
 - 3b: Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all.
- **Goal 5: Achieve gender equality and empower all women and girls’.** This goal includes the following targets to be reached by 2030:
 - 5.2: Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation
 - 5.6: Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences

⁶⁷ World Health Organisation. 2004. Reproductive Health Strategy. Geneva. Accessed at http://whqlibdoc.who.int/hq/2004/WHO_RHR_04.8.pdf on January 25, 2015.

⁶⁸ World Health Organisation. 2005. Linking Sexual and Reproductive Health and HIV/AIDS - An annotated inventory. Accessed

90-90-90 Treatment Target to end AIDS⁶⁹

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).
3. By 2020, 90% of those on ART having an undetectable viral load.

⁶⁹ 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_o.pdf on May 20, 2015.

ANNEX 4: GLOSSARY OF TERMS

abstinence	Abstinence is a conscious decision to avoid certain activities or behaviours. Different people have different definitions of sexual abstinence. For some, it may mean no sexual contact. For others, it may mean no penetration (oral, anal, vaginal) or only 'lower-risk' behaviours..
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
adherence	Taking medications exactly as prescribed. Poor adherence to an HIV treatment regimen increases the risk for developing drug-resistant HIV and virologic failure.
adolescent	The World Health Organization uses the 10-19 year age range to define adolescence.
affected person	A person whose life is changed in any way by HIV and AIDS, due to the broad impact of the epidemic.
age-specific fertility rate	The number of births occurring during a given year or reference period per 1,000 women of reproductive age classified in single- or five-year age groups.
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.
barrier methods	Barrier methods of contraception prevent pregnancy by physically or chemically blocking the entrance of sperm into the uterine cavity. Some, particularly condoms, help to protect against sexually transmitted infections, including HIV infection. Barrier methods include condoms, diaphragms, female condoms, spermicides and sponges.
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.

birth rate		The number of live births per 1,000 population in a given year. Also called crude birth rate.
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.
comprehensive education	sexuality	Education about all matters relating to sexuality and its expression. Comprehensive sexuality education covers the same topics as sex education but also includes issues such as relationships, attitudes towards sexuality, sexual roles, gender relations and the social pressures to be sexually active, and it provides information about sexual and reproductive health services. It may also include training in communication and decision-making skills.
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.
contraceptive prevalence rate		The percentage of all women of reproductive age or married women of reproductive age, typically aged 15-49, who are using a method of contraception.
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).
dual protection		Dual protection is protection against both unintended pregnancy and sexually transmitted infections, including HIV. For sexually active individuals, a condom is the only device that is effective for dual protection. Dual protection can also be achieved by using condoms with another method of contraception, referred to as dual method or double protection.
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.
family planning	The WHO indicates that family planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility. A woman's ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy.
fertility rate	Measures which relate the number of births in a given period to the number of women of reproductive age (unlike the crude birth rate, which relates births to the whole population). The general fertility rate relates births in a particular period, usually a year, to women aged 15-49 or 15-44 years at that time.
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-based violence	The United Nations General Assembly in 1993 adopted the definition of violence against women as "any act that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. It encompasses, but is not limited to: physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital cutting and other traditional practices harmful to women, non-spousal violence and violence related to exploitation; physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere; trafficking in women and forced prostitution; and physical, sexual and psychological violence perpetrated or condoned by the state, wherever it occurs."
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-responsive programing	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.

information, education and communication	<p>A programme to ensure that clients or potential clients of sexual and reproductive health services are given the means to make responsible decisions about childbearing and about their sexual and reproductive health.</p> <p>Information involves generating and disseminating general and technical information, facts and issues, in order to create awareness and knowledge.</p> <p>Education, whether formal or non-formal, is a process of facilitated learning to enable those learning to make rational and informed decisions.</p> <p>Communication is a planned process aimed at motivating people to adopt new attitudes or behaviour.</p>
injectables	<p>Hormonal contraception. Systemic methods of contraception based on either a progestagen combined with an oestrogen or a progestagen alone. The methods of delivery include pills (oral contraceptives), injectables and implants. All are reversible.</p>
intrauterine (contraceptive) device	<p>A long-term, reversible method of contraception, involving the insertion into the uterus of a small flexible device of metal/plastic/hormonal materials. IUDs are effective for at least four years, and many for much longer.</p>
key population	<p>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.</p>
life threatening illnesses	<p>An illness or situation that makes it possible that the person affected will die.</p>
linkages	<p>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.</p>
linkage and retention in care	<p>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.</p>
maternal mortality rate	<p>The number of deaths of women due to pregnancy and childbirth complications per 100,000 women aged 15-45 or 15-49 years. This rate measures a woman's lifetime risk of dying associated with reproduction.</p>
Millennium Development Goals (MDGs)	<p>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.</p>

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'.
mother-to-child transmission	Transmission of HIV from women to their foetus during pregnancy, delivery or their infant during breast-feeding.
multiple sexual partnerships	A relationship between men and women who have more than one sexual relationships at the same time. These relationships 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.
reproductive age	The span of ages at which individuals are capable of becoming parents. The phrase can be applied to men and women but most frequently refers to women.
reproductive health	The NISP endorses the definition of reproductive health agreed at the International Conference on Population and Development, which stated: "Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility.
reproductive rights	These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to

attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.

reproductive tract infection	A general term for infections affecting the reproductive organs. RTIs include three types of infection: sexually transmitted infections (STIs), infections which are caused by overgrowth of organisms naturally present in the genital tract, such as bacterial vaginosis and vulvovaginal candidiasis, and infections that are a consequence of medical treatment.
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 newborn 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.
sexual and reproductive health services	Defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems. It also includes sexual health.

sexual rights	Sexual rights as defined at the Fourth World Conference on Women, which stated that: "The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences."
sexuality	The sexual knowledge, beliefs, attitudes, values, and behaviours of individuals. Its dimensions include the anatomy, physiology, and biochemistry of the sexual response system; identity, orientation, roles and personality; and thoughts, feelings, and relationships. The expression of sexuality is influenced by ethical, spiritual, cultural, and moral concerns.
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>
total fertility rate	The average number of children that would be born alive to a woman during her lifetime if the age-specific fertility rates of a given year applied throughout her childbearing years.
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.
unmet need for family planning	Estimates of women who would like to prevent or delay pregnancy but are not using contraception, either because they lack knowledge about family planning or access to services, or because they face cultural, religious and family obstacles.
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 includes 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 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.
young people	Persons who are aged between 10-24 years.
youth	The World Health Organization refers to those in the 15-24 age range as youth