Global AIDS Monitoring Report

Jamaica

2020

THE GLOBAL AIDS MONITORING REPORT

OF JAMAICA 2020

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List of Acronyms

AC	**Adherence Counsellors**

AHF	AIDS Healthcare Foundation
AIDS	Acquired Immune Deficiency Syndrome
ALHIV	Adolescents Living with HIV
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASRH	Adolescent Sexual and Reproductive Health
BCC	Behaviour Change Communication
CD4	Cluster of Differentiation
CBO	Community-based Organization
CCM	Country Coordinating Mechanism
CF	Community Facilitators
CLMIS	Contraceptive Logistics Management Information System Survey
CM	Case Manager
CRH	Cornwall Regional Hospital
CSO	Civil Society Organization
CVCC	Caribbean Vulnerable Communities Coalition
DBS	Dry Blood Spot
DBST	Dry Blood Spot Testing
DHIS2	District Health Information System 2
EEHR	Enabling Environment and Human Rights
EMTCT	Elimination of Mother-To-Child Transmission
FAACC	Fort Augusta Adult Correctional Centre
FHU	Family Health Unit
FSW	Female Sex Worker
GIPA	Greater Involvement of Persons with HIV/AIDS
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOJ	Government of Jamaica
HARC	Horizon Adult Remand Centre
HATS	HIV/AIDS Tracking System
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HSTU	HIV/STI/TB Unit

IEC	Information, Education and Communication Material
ITECH	International Training and Education Center for HIV
IUCD	Intra-uterine Contraceptive Device
JADS	Jamaica Anti-Discrimination System
JaPPAIDS	Jamaica Paediatric, Perinatal and Adolescent HIV/AIDS Programme
JASL	Jamaica AIDS Support for Life
JCW+	Jamaica Community of Positive Women
JEF	Jamaica Employer's Federation
JFJ	Jamaicans for Justice
JN+	Jamaica Network for Seropositives
JSC	Joint Select Committee
JYAN	Jamaica Youth Advocacy Network
KABP	Knowledge, Attitude, Behaviour and Practices
KP	Key population
LFA	Local Funding Agent
MLSS	Ministry of Labour and Social Security
MOE	Ministry of Education
MOFPS	Ministry of Finance and Public Service
MOHW	Ministry of Health and Wellness
MOJ	Ministry of Justice
MSM	Men who have Sex with Men
NBACC	New Broughton Adult Correctional Centre
NERHA	North East Regional Health Authority
NFPB	National Family Planning Board
NGO	Non-Government Organization
NHF	National Health Fund
NHP	National HIV/STI Programme
NISP	National Integrated Strategic Plan
NPHL	National Public Health Laboratory
NSU	National Surveillance Unit
OSH	Occupational Safety and Health
PAHO	Pan American Health Organization
PEPFAR	President's Emergency Plan for AIDS Relief
PCR	Polymer Chain Reaction

PCPM	Programme Coordination, Planning and Management
PDSA	Plan Do Study Act
PHDP	Positive Health Dignity and Prevention
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV/AIDS
PLACE	Priority for AIDS control Efforts
PMTCT	Prevention of Mother-To-Child Transmission
PN	Patient Navigators
PSIS	Prevention Services Information System
RFACC	Richmond Farm Adult Correctional Centre
RHA	Regional Health Authority
S&D	Stigma & Discrimination
SERHA	South East Regional Health Authority
SI	Strategic Information
STI	Sexually Transmitted Infection
SRH	Sexual and Reproductive Health
ST. CACC	St. Catherine Adult Correctional Centre
SWIT	Sex Worker Implementation Tool
Tb	Tuberculosis
TCS	Treatment, Care and Support
TFACC	Tamarind Farm Adult Correctional Centre
TG	Transgender/Persons of Trans-experience
TGW	Women of Transgender Experience
TOT	Training of Trainers
TransIT	Trans Implementation Tool
TRAT	Treatment Readiness Assessment Tool
TSACC	Tower Street Adult Correctional Centre
TSIS	Treatment Site Information System
TWG	Technical Working Group
UCSF	University of California, San Francisco
UIC	Unique Identifier Code
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNJT	United Nations Joint Team

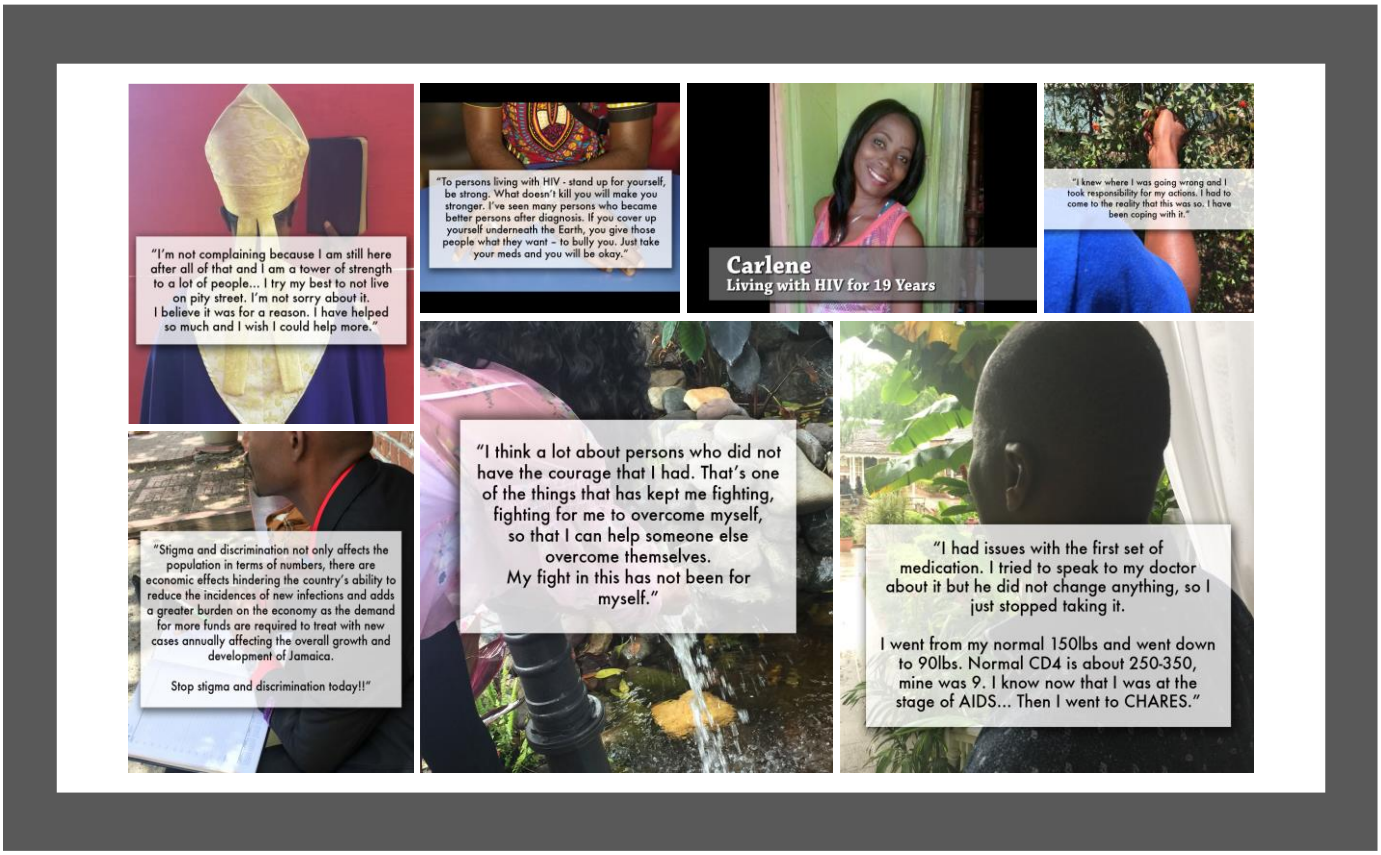
USAID	United States Agency for International Development
VBI	Venue-based Intervention
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
WRHA	Western Regional Health Authority
YATWG	Youth and Adolescent Technical Working Group

Featured Story

A social media campaign launched by NFPB, using a human-interest perspective, highlighted the negative effects on and resilience of people living with HIV in Jamaica.

The campaign featured ten (10) PLHIVs who told their stories - from diagnosis, to stigma and discrimination to finding the strength to persevere and help other PLHIV. Recruitment for the campaign was through the GIPA programme, a strong part of the enabling environment and human rights component. Among the persons interviewed were 7 males and 3 females. Of the 10 participants, 8 preferred to remain anonymous. Each story was delivered by means of short quotes of important points accompanied by a photo, audio or video. The ten (10) stories were posted during the week of July 15, 2019 on the Facebook and Instagram pages of the NFPB.

Pictured below are selected photos from the social media campaign:

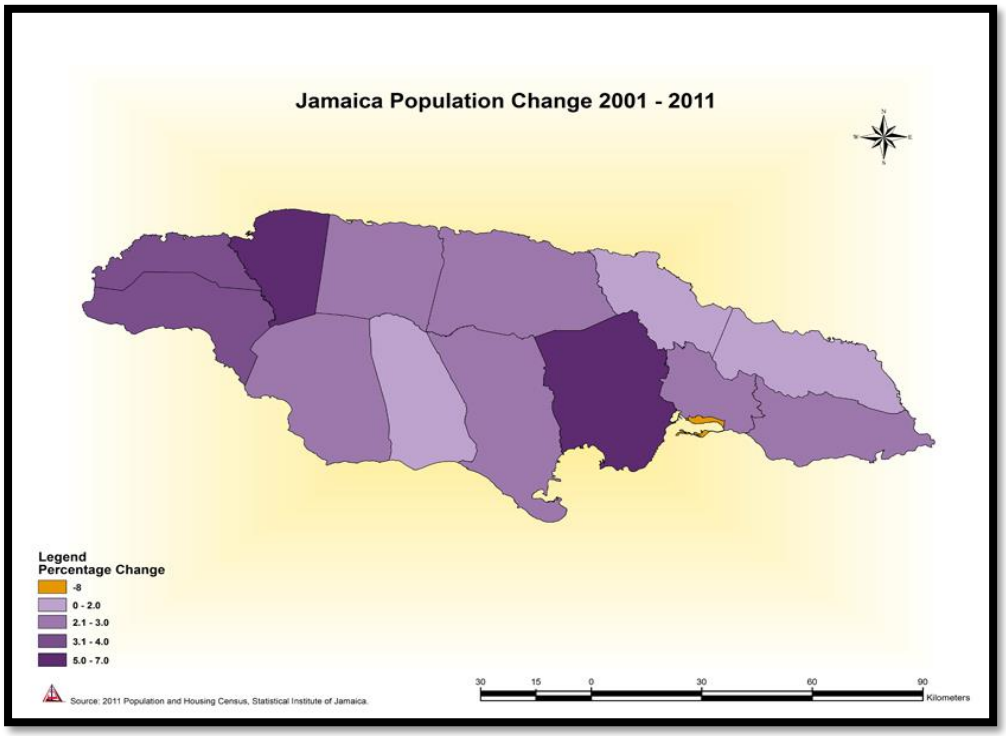


I. Introduction

Jamaica remains committed to the 2016 United Nations Political Declaration on Ending AIDS and the UNAIDS 2016-2021 Strategy. Since the adoption of these two key documents, the country has allocated vast resources to addressing the epidemic. This has been achieved through the mobilisation of the national HIV prevention effort, in addition to cultivating strong, supportive relationships with international development agencies and multilateral partnerships. To this end, Jamaica was congratulated for its 100% compliance in reporting on global HIV/AIDS commitments through reports such as the Global AIDS Monitoring (GAM) report with the assistance of UNAIDS, civil society and other partners.

The largest English-Speaking country in the Caribbean, Jamaica is approximately 235 kilometres long and 82 kilometres wide, with a total land area of 10,991 squared kilometres. Jamaica is surrounded by the Caribbean Sea and have as its closest neighbouring countries Cuba, 145 kilometres north, and Haiti, 177 kilometres west. Jamaica is located 901 kilometres below the south-eastern part of Florida, in the United States of America.

Jamaica proudly boasts a population of 2,727,503 (STATIN, 2018). Based on the Jamaica Population Change 2001-2011 (Pictured), the two darkest shaded parishes represent the highest in population density, areas in which most people reside. Additionally, these two areas are also home to two of the three municipalities in the country, Montego Bay, in the parish of St. James (smaller of the two darkest shaded) and Portmore located in the parish of St. Catherine, to the west of the capital Kingston. Geographically, the figure shows the 14 parishes (states or provinces) into which Jamaica is divided.



1.2 Jamaica's HIV Epidemic

Jamaica has an estimated 32,617 people living with HIV (Spectrum, 2018). It is further estimated that 84% or 27,324 people are aware of their HIV status. Compared to 2017 when the estimated HIV prevalence was 1.8%, 2019 estimated prevalence in the general population is 1.5%, a marked decrease and a tangible change in the trajectory of the HIV epidemic in the country. Jamaica also faces stark realities of an HIV epidemic concentrated among key populations.

Table 1 shows that people of transgender experience face alarming HIV prevalence of 51%, while among MSM there is an estimated prevalence of almost 30%. These are staggering statistics that demonstrate that although the country has an estimated HIV

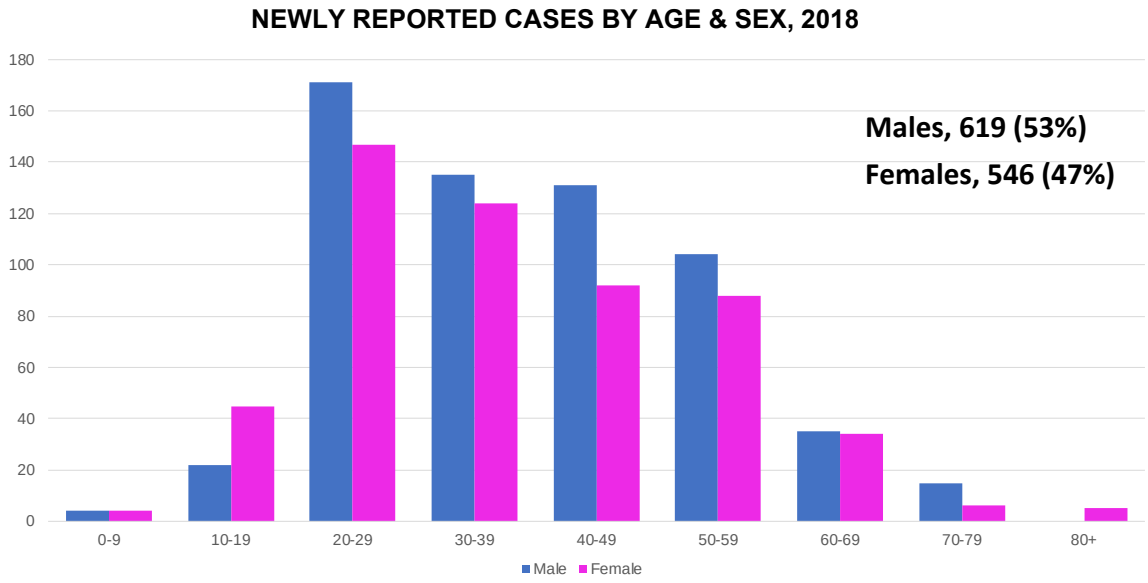
prevalence of under 2%, enormous effort is needed to address the levels of inequality that exist among the key populations.

Table 1: Estimated HIV Prevalence in Jamaica, 2019

Population Category	**Prevalence (%)**
General population (UNAIDS, 2018)	1.5%
TGW (2018)	51.0%
MSM (2018)	29.6%
Homeless (2014)	13.9%
Prison Inmates (2018)	6.9%
FSW (2017)	2.0%

In 2018, there were 1,165 newly reported HIV cases in Jamaica, 32 fewer cases when compared to 2017. Figure 1 shows the disaggregation of all the newly reported cases by age and sex. 53% of newly reported cases were males and 47% were among females. More new cases were found among the age group 20-29 years, with a similar number of new cases found among men in the age groups of 30-39 and 40-49 years. Interestingly, older women in age group 40-49 and 50-59 years were reporting a similar number of cases. The distribution of reported new cases reflects a similar trend to 2017. Also, it acknowledges new cases of vertical transmission among new-born babies during the period.

Figure 1: Newly Reported Cases by Age & Sex, 2018



34% of reported new HIV cases were found in the key and vulnerable populations. Table 2 presents the percentage of new cases by key and vulnerable populations. Youth aged 15-24 years accounted for 16% of new reported cases, even more than MSM population, of 10%. Increasingly, the youth population has become more vulnerable to HIV in Jamaica, a trend that must witness comparable interventions and attention. Prison inmates remain a vulnerable population requiring increased attention. Female Sex Workers reported new cases is consistent at 2% from 2017.

Table 2: Newly Reported Cases by Key & Vulnerable Populations, 2018

KEY & VULNERABLE POPULATIONS	% NEW CASES
MSM	10%
FSW	2%
Prison Inmates (current/past)	6%
Youth (15-24)	16%

TGP, Homeless, disabled persons: <1%

1.3 Inclusiveness of Stakeholders in the Collation Process for the GAM Report

In keeping with the UNAIDS guidelines for GAM reporting processes, Jamaica has been consistent in its approach to engage and attain high levels of participation through national consultations. Through national consultations, civil society partners, national agencies and international partners were engaged through a series of stakeholder meetings.

Under the guidance of the lead agencies, the National Family Planning Board and Ministry of Health and Wellness, the GAM Steering Committee comprising national representatives of the HIV programme, government agencies, CSOs including PLHIV networks and bilateral agencies, convened to chart an implementation workplan (refer to Appendix C for list of stakeholders who attended the various GAM meetings). Through this workplan, activities and timelines were scheduled, ensuring on time submission of, and comprehensive information in, the GAM report.

II. 2020 Fast-Track commitments and expanded targets to end AIDS

COMMITMENT 1: Ensure that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020

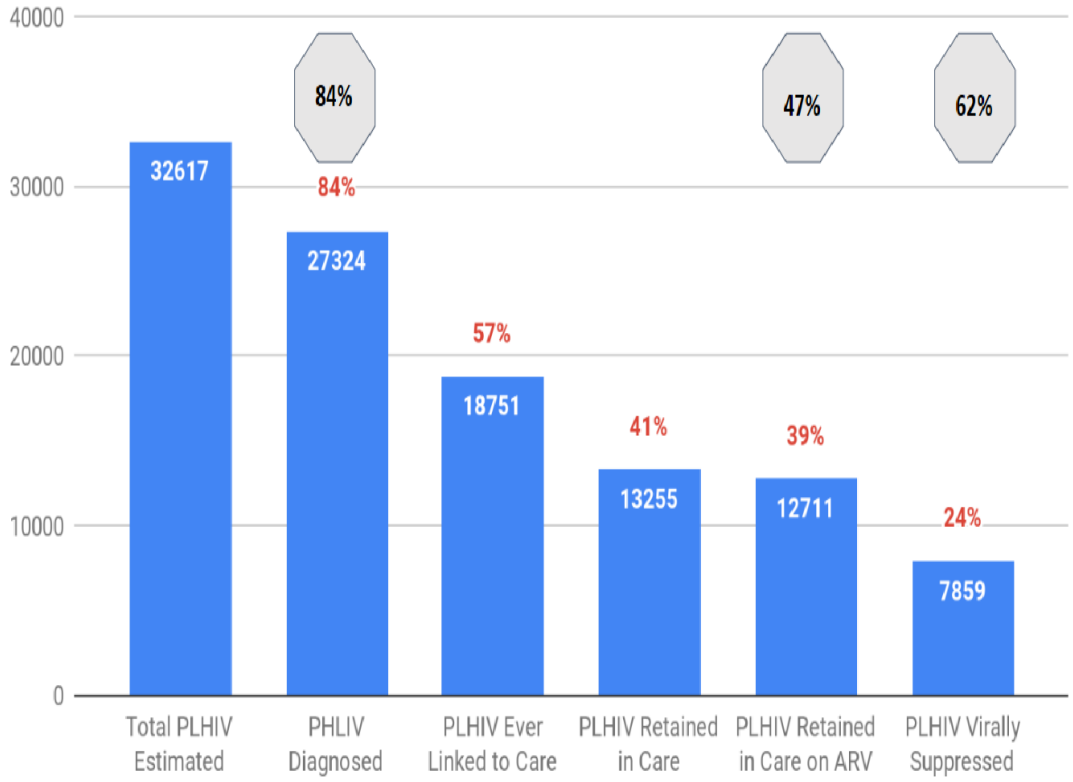
1.1 People living with HIV who know their HIV status

Jamaica continues to accelerate efforts in its commitment to the first 90 in the 2020 Fast-Track commitment to end AIDS. In 2018, 84% or 27, 324 people living with HIV were estimated to have known their HIV diagnosis (Figure 1). HIV testing has become accessible to the general populations with germane efforts of testing key populations continue to dominate targets for outreach interventions.

1.2 People living with HIV on antiretroviral therapy

In 2018, 32,617 people were estimated to be living with HIV in Jamaica. Based on the treatment site databases, 12,711 or 47% persons are documented to be retained in care and on antiretroviral therapy (Figure 1). Although this requires significant progress to achieve the 90% target by 2020, Jamaica is doing well transitioning people to ARV once they are retained in care. To achieve country level target by 2020, this will require shifting emphasis to people diagnosed with HIV, a significant number to engage them in care. The Epi data (2018) shows that once people are engaged in care, 96% of people will transition to ARV.

Figure 1: 2018 Treatment Cascade



1.3 People living with HIV who have suppressed viral loads

Figure 1 shows that 62% of people living with HIV who are on treatment have suppressed viral loads. Jamaica has embarked on initiatives to move the country closer to achieving the third 90% goal by 2020. One such initiative is the Jamaica Quality Improvement Collaborative, a partnership between International Training and Education Center for Health (I-TECH) and the Ministry of Health and Wellness. Although there has been different focus over the past six years, since 2018, the aim has been centred on improving viral suppression rates, moving Jamaica to achieving 90% viral suppression by 2020. Sites across the country are implementing various PDSA cycles focused on viral suppression but also include activities that span the HIV care continuum.

Additionally, PAHO supported the Ministry of Health and Wellness to develop a Retention in Care and Adherence Strategy. The process of development was inclusive

of stakeholder participation, ensuring that the regions and key stakeholders were represented in the process. The document includes:

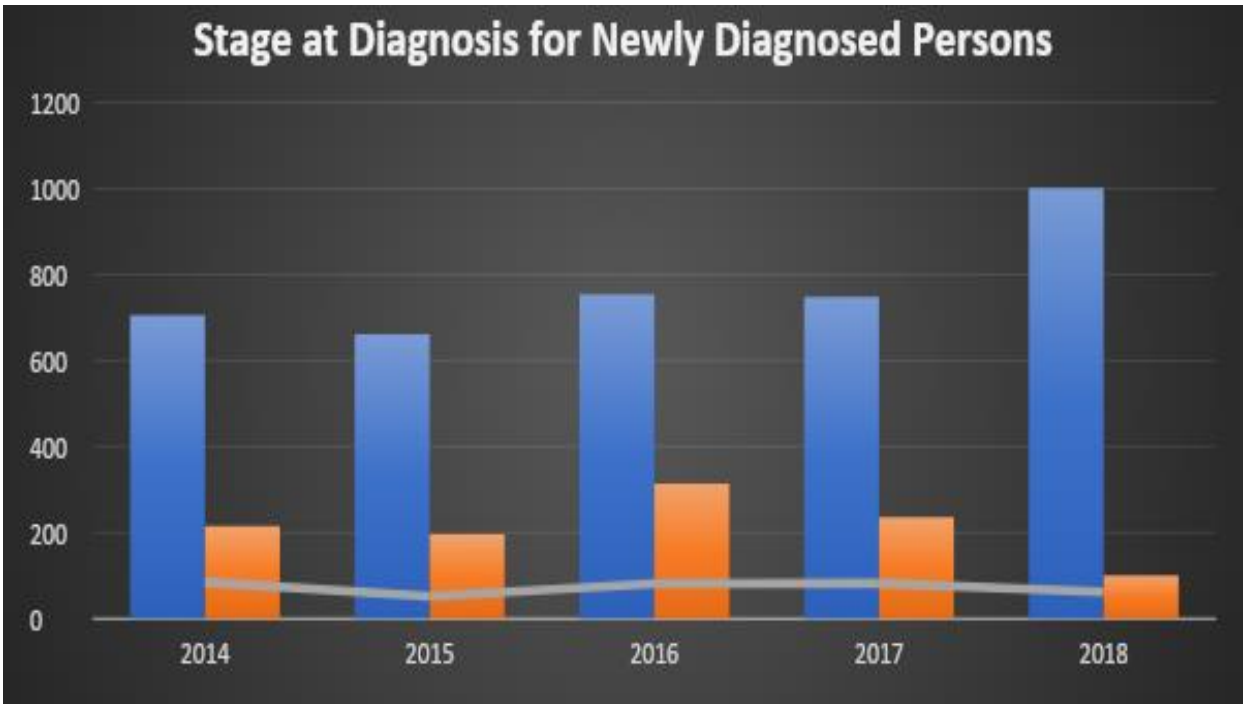
1. Revision of the current landscape of retention interventions in Jamaica
2. Comparing Jamaica with international evidence-based strategies; both narrative and tabular, which outlined areas of potential gaps
3. Civil society as an implementation partner was elaborated
4. A variation of case management modality - Team-based Adherence for Patient Support (TAPS)
5. Evidenced-based intervention, outlining potential areas for strengthening gaps
6. Treatment team composition, workflow and tools

The Retention in Care and Adherence Strategy aims to support an increase in people retained in care and who achieve viral suppression. It proposes slight shifts to the workflow and patient management protocols to enhance patient retention and ultimately viral suppression experienced at sites.

1.4 Late HIV diagnosis

Jamaica has worked assiduously to increase access to treatment support, thereby reducing the late HIV diagnosis among newly reported cases. In 2018, 101 persons were diagnosed with AIDS on first diagnosis, a significant decrease from the previous four years (Figure 2). Similarly, there was a reduction in the number of persons diagnosed at death. Increased testing campaigns have supported the country in diagnosis persons earlier.

Figure 2: Stage at Diagnosis for Newly Diagnosed Persons, 2014-2017



1.5 Antiretroviral medicine stock-outs

The country made significant strides in enabling uninterrupted access to ARV medicines. No national stock out of ARVs was experienced in 2019. It may be noted that some sites may have had site specific stock outs due to procurement and distribution processes of ARVs through the National Health Fund Activity, a newer model of ARV distribution. However, sites maintained and had access to adequate buffer stock of ARVs. Additionally, within treatment site pharmacies, there reports of limited availability for ARVs due to space constraints.

1.6 AIDS mortality

One hundred and seventy-nine (179) deaths were reported in 2018. Of the 179 deaths, males account for 104 or 58% of deaths while 75 deaths were reported among females. Males experience higher AIDS mortality compared to females with significant differences experienced in the age group 40 to 49 years. However, in all age cohorts, males are more at risk of mortality than females. Ensuring that treatment, care and support interventions reach males who struggle with adherence or medication failure (drug resistance) is vitally important in promoting longer and healthier lives.

Collaborative efforts to develop a HIV Drug Resistance Strategy was actualized in 2019. PAHO Jamaica organised and facilitated an in-country mission to review and propose key activities for routine surveillance of HIVDR. An effective mission was executed over the period August 5 – 10, 2019, which led to high level support and buy-in to the process and activities for the strategy. The final HIVDR Strategy for the National HIV Programme was submitted in October 2019 and was reflected in the National Strategic Plan 2020-2025, a process that envelop the work done for the HIVDR.

COMMITMENT 2: Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018

2.1 Early infant diagnosis

In 2019, 1,072 samples were submitted for DNA PCR testing with 8 (0.7%) positive HIV cases through vertical transmission. The majority of clients were known PLHIV who defaulted from care and who presented to the hospital for delivery. Through interviews and discussions with mothers, it is believed that the main reason for vertical transmission is lack of disclosure to partners. As a method of prevention, breastfeeding was discouraged and initiated in order to protect baby from contracting the virus.

Of the 1,072 samples received, 1,000 samples or 93% were negative while 6% were rejected. The main reason for rejection was questionable sample integrity, which is directly linked to improper storage of desiccants, resulting in moisture build up on samples. On December 23 and 24, a national DBST training was held with the PMTCT Nurses, Coordinators and Chief Medical Technologists who were re-sensitized to DBS sample collection, storage and transportation. The training was a mix of didactic and practical methods and included job aids, which were distributed during the training and to all relevant regional offices.

2.2 HIV testing among pregnant women

The regional lab reports show that at least 32,398 HIV tests were done in antenatal clinics across the island in 2019, with a yield of 0.62% (201 positive tests).

2.3 Preventing the mother-to-child transmission of HIV

Jamaica is committed to the Elimination of Mother to Child Transmission (EMTCT) of HIV and Syphilis. The Prevention of Mother-to-Child Transmission (PMTCT) Programme has adopted the WHO EMTCT annual targets:

- 2% or less rate of MTCT for HIV
- Less than 50 new paediatric HIV infections per 100,000 live births
- Less than 50 cases of Congenital Syphilis per 100,000 live births

The EMTCT Oversight Committee continued in 2019 to provide technical guidance in the central processes related to PMTCT at the national level. Through quarterly updates on the PMTCT programme, the Committee was concerned about the spike in the number of cases of HIV in 2017. Although there was slightly more than 50% decrease in 2018, the cases increased in 2019 (Table 3). The multiagency Committee supported HSTU in developing a corrective roadmap for the programme leading to national audits of PMTCT programme sites.

Table 3: EMTCT Validation Indicators for 2017, 2018 and 2019

Impact indicators	***Target***	***2017***			***2018***			***2019***		
		Result	***Num***	***Den***	***Result***	***Num***	***Den***	***Result***	***Num***	***Den***
HIV MTCT rate	***<2%***	***5.40%***	***16***	***295***	***2.10%***	***7***	***338***	***2.20%***	***9***	***410***
Annual rate of new inf. per 1000 infections	***<0.3 /0.5 -2018***	***0.4***	***16***	***35,959***	***0.2***	***7***	***35,043***	***0.3***	***9***	***32587***

Impact indicators	Target	2017			2018			2019		
		Result	Num	Den	Result	Num	Den	Result	Num	Den
Annual rate of CS per 1000 live births	<0.5	0.22	8	35,959	0.51	18	35,043	0	0	32587

Through a series of audits that started in 2018, a number of challenges were identified across all PMTCT programme sites. Primarily, these challenges were:

- Low retention in care at treatment sites among PLHIV females of reproductive age
- Non-compliance with testing antenatal clients; linkage to care and treatment
- All pregnant PLHIV not being Case Managed
- Delivery plan not developed and or not executed
- Inadequate follow up of mother and child post delivery
- Inconsistent documentation and poor data quality

Through the support of the EMTCT Oversight Committee, the HIV/STI/TB Programme in the Ministry of Health and Wellness and the Pan American Health Organization (PAHO) in 2019 commissioned the services of a National EMTCT Field Validation Coordinator. The main role of the National EMTCT Field Validation Coordinator was to identify gaps in patient management at the 16 PMTCT programme sites across the island and to assist sites align activities to the PMTCT protocols. Through this intervention, site audits were completed for non-compliant sites to promote increased compliance with the PMTCT protocols. Generally, there were seven (7) areas that comprised the site audits. These were:

- The PITC programme for HIV and Syphilis at labour and maternity wards
- Completeness of documentation in delivery book
- Rapid test records (HIV and Syphilis)
- Registrar Generals Log
- ARVs administered
- Feeding history

- Referrals for follow up care for mother and child

Additionally, the site audits included a review of the antenatal, intranatal and postnatal period documentation and management of the mother and child.

During 2019, several national PMTCT meetings were held including a national PMTCT case review meeting in July. The national PMTCT case review focused on the management of HIV positive paediatric cases from each of the four regions and included a detailed review of the adherence measures instituted at Parish level to guide compliance with the national paediatric HIV management protocols.

As an outcome from the field audits and the national case review meetings, audit reports and corrective action plans were provided to the Regional Health Authorities (RHAs). Measures to improve the retention levels of PLHIV women of reproductive age, re-sensitization in the obstetric management protocols for the pregnant PLHIV woman, postnatal management of the infant, referral for continuity of care for both mother and infant and increased documentation at all stages of patient care.

In summary, direct PMTCT programme interventions in 2019 can be captured in the following 10 activities:

1. Scheduled PMTCT meetings in all regions, including case reviews conducted during parish PMTCT meeting or parish HIV/STI team meetings
2. PMTCT Nurses and Coordinators trained in Motivational Interviewing
3. All HIV positive paediatric clients now in care and on ART
4. Increase in the cadre of PMTCT Nurses
5. Sustainability of the programme with the absorption of the cadre of PMTCT Nurses by the regions and the GOJ budget providing programme specific funding for 2019/2020
6. Improved communication with the Family Health Unit to address documentation gaps related to maternal and child health services
7. Training of PMTCT Nurses and support staff in DBST

8. Training of PMTCT Nurses, Coordinators and Senior Public Health Nurses in data collection, collation and reporting; inclusive of the treatment site (TSIS2) database
9. Training of obstetric teams in the clinical management of syphilis positive and PLHIV pregnant clients by the Clinical Mentor
10. Updated HIV Clinical Manual, job aides and testing algorithms disseminated to region and parish level staff

The country remains optimistic in achieving the WHO EMTCT annual targets. Through increased communication with field sites; closer monitoring and evaluation of data, and laser-beam focus on specific target interventions, the National HIV/STI/TB Programme is confident that these steps will move the national programme within reach of attaining the elimination of mother to child transmission of HIV and Syphilis in Jamaica.

Commitment 3: Ensure access to combination prevention options, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations—gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners

3.1 Estimates of the size of key populations (A–E)

Size estimates for key populations were undertaken in 2018 and reported in previous GAM report. The country continued to rely upon the size estimate exercise to guide all key population intervention during 2019 (Table 4). By way of a recap, a combination of different methods was utilized in estimating the size of key populations. The methods included unique object multiplier, the wisdom of the crowds, service multiplier, literature review and a synthesis of methods using the anchored multiplier. Additionally, national bio-behavioural surveys contributed to these estimates. Notable 2017 and 2018 studies included:

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

Additionally, broad and extensive consultations played a key role in advancing size estimates for key populations. Contributors included national and international academic experts, epidemiologists, civil society experts on key populations, UNAIDS, UNICEF, and government officials.

Table 4: Estimates of the size of key populations

Key population	2018estimated population
men who have sex with men (MSM)	42,375 (95% CI: 28,278 – 58,855)
transgender (TGW)	3,841 (95% CI: 3,142 – 4,646)
sex workers and their clients	18,696 (2014)

Source: 876 Study: Integrated Biological & Behavioural Surveillance Survey with Population size estimation among MSM & TG in Jamaica. Ministry of Health, 2018.

3.2 Antiretroviral therapy coverage among people living with HIV in key populations

Although government provides the most comprehensive treatment services for people living with HIV, treatment coverage is also found among CSOs, namely, Jamaica AIDS Support for Life and AIDS Healthcare Foundation. Collectively, in 2019, at all non-government sites covering, AHF, JASL (Ocho Rios), JASL (Kingston), JASL (Montego Bay), including four (4) private HIV providers, the total ever linked is 1266 people, with retention numbers of 767 and total populations retained on ARV is 727. Viral uptake across these sites is 575 and viral suppression is 510 people living with HIV.

Further, civil society organizations have also risen to support national treatment goals. Jamaica Community of Positive Women (JCW+) supported 18 women in 2019 by increasing their treatment literacy on issues of adherence to medication and understanding treatment regimens. The results are encouraging, with 6 women achieving viral suppression and significant reduction in viral loads among the cohort.

- Community Facilitators (CF) Deployment Programme

In 2019, the Jamaican Network of Seropositives (JN+), in fulfilling its mandate, sought to utilize effective avenues to provide care and support to its members and other persons

living with HIV (PLHIV). A notable and highly successful initiative of JN+ is the community facilitator programme. Funded by USAID, the programme predominantly provides for support and access to care with the goal of achieving viral suppression during a 3-6 month timeframe.

Community Facilitators are persons living with HIV tasked to provide social, vocational, psychosocial and emotional support to their peers. The structure of the programme involves the allocation of 5-10 clients per week to each CF, who monitors and provides care and support throughout that week. This engagement is facilitated through peer to peer support group sessions, sensitization sessions, one-on-one sessions, appointment reminder phone calls and follow-up services for PLHIV who are classified as lost to follow up (LTFU).

Despite the funding constraints in 2019, which resulted in the loss of 4 CFs due to non-renewal of contracts, CFs were active at two rural and urban treatment sites. The following are key successes achieved in 2019:

1. 55 PLHIVs were assigned and 19 reached viral suppression
2. 106 One-on-one sessions were conducted from April – September 2019
3. 40 group sessions were conducted by CFs and a total of 69 group sessions supported by CFs
4. 1,192 client calls were made regarding laboratory tests (CD4 and viral load tests), clinic appointments and re-engagement in care (LTFU)
5. 27 clients returned to care

3.3 HIV testing among key populations

Effectively, outreach strategies for key populations continued from the previous reporting cycle. There was a comprehensive package of prevention services that includes condom distribution, HIV/STI testing among FSW, MSM and TG populations. Additional interventions included skills building workshops, certified skills trainings, site based and

venue-based interventions, use of peer links, identifying hidden key populations, one to one and snowballing.

In 2019, 20.5% of all HIV tests done were among key populations while 79.5% was among the general population (GP). Among the MSM population, 3.89% were found to be reactive to HIV, while 0.77% was found among FSW, a consistently decreasing trend among FSW (Table 5). With lower numbers of TG tested, an alarming 12.3% were found to be reactive to the HIV test, while GP results showed 0.45% reactive to the HIV test.

Table 5: HIV Testing & Reactive Numbers Among Key Populations, 2019

HIV Tests & Reactive Numbers Among Key Populations		
Target Population	**Tested**	**Positive**
MSM	**5315**	**207**
FSW	**6059**	**47**
TG	**300**	**37**
GP (sexually active men and women)	**46445**	**210**
IN (inmates)	**234**	**1**
MSM-IN (MSM inmates)	**4**	**1**
Grand Total	**58357**	**503**

Partnership remained strong with the Department of Corrections through the prevention activities within prisons. Table 4 shows that over 200 inmates accessed HIV testing services. The Adult Correctional Centres which partnered with the prevention team during 2019 were, Fort Augusta Adult Correctional Centre, St. Catherine Adult Correctional Center, Tamarind Farm Adult Correctional Centre and Tower Street Adult Correctional Center. Special acknowledgement is made of the Manchioneal Police Station, which permitted testing among remanded persons.

3.4 Syphilis testing among key populations

The prevalence of STI among key and vulnerable populations remains a concern. The growing number of new Syphilis cases indicates that greater risk reduction interventions

are pivotal in stemming the growing STI epidemic. Table 6 shows that the highest reactive cases were among TG recording 26% reactive, followed by 10% among MSM. FSW recorded 3.6%, a relatively low number of new cases particularly in light of experiencing a higher volume of testing.

Table 6: Syphilis Testing & Reactive Numbers Among Key Populations, 2019

Syphilis Tests & Reactive Numbers		
Row Labels	**Count of UIC**	**Reactive**
MSM	**4967**	**504**
FSW	**5899**	**215**
TG	**286**	**75**
GP (sexually active men and women)	**45653**	**877**
IN (inmates)	**234**	**4**
MSMIN (MSM inmates)	**4**	**2**
Grand Total	**57043**	**1677**

3.5 People receiving pre-exposure prophylaxis

Jamaica has moved to introduce pre-exposure prophylaxis (PrEP) as a biomedical option that prevents HIV transmission. During 2019, meticulous work was undertaken in two areas; first, in the development of an Institutional Review Board approved pilot study and second, through the development of IEC materials for both providers and PrEP-users.

Implemented in 2020, the pilot study aims to introduce PrEP for sero-discordant heterosexual couples who are in preconception and also for MSM within a community clinic. The study aims to recruit 25 couples and 50 MSM respectively. Additionally, the pilot study will review the appropriateness and feasibility of PrEP for STI clinic attendees.

In 2019 there was a partnership between PAHO and MOHW as part of support for PrEP roll-out. PAHO led the creation of PrEP IEC materials for both PrEP-users and

providers. The materials were intended to address PrEP efficacy and the utility of PrEP as well as respond to common questions asked about PrEP from patients and clinical providers who are new to PrEP as a biomedical method for HIV prevention.

Additional to the PrEP pilot study in 2019, was study on the awareness and willingness to use PrEP among MSM and TG populations through the 876 study. Although conducted in 2018, these findings were not available and not reported in the last GAM report.

- **The 876 Study: Integrated Biological and Behavioural Surveillance Survey with Population Size Estimation Among Men who have Sex with Men and Transgender Persons in Jamaica**

Limited data from the 876 Study was reported in Jamaica 2019 GAM report, however, complete data analysis and the narrative report was only disseminated in March 2019. Interesting findings on stigma and discrimination, healthcare utilization and access to services are relevant in understanding issues of avoidance to health care by key populations.

PrEP Awareness, Willingness, and Use

Table 2 describes PrEP indicators based on the sub-sample of those who tested HIV-negative and those who thought they were HIV-negative (i.e., would be potentially eligible for PrEP). Among this group of MSM, 43.9% were aware of PrEP. Among their TGW counterparts, 25.3% were aware of PrEP (Table 7). After PrEP was described to participants, 73.3% of potentially eligible MSM and 58.7% of TGW were at least somewhat willing to use PrEP. Preferred sites to receive PrEP tended to be outside of HIV care clinics, particularly at health centres or through NGO or health department outreach.

Table 7: PrEP Knowledge and Use among HIV-negative and Unaware HIV-Positive MSM and TGW

	MSM (n=428)		TGW (n=75)		Total (n=514)			
	Crude		Crude		Crude		RDS-Adjusted	
	n	%	n	%	n	%	%	95% CI
Aware of PrEP								
Yes	188	43.9	19	25.3	210	40.9	48.5	43.5-53.4
No	200	46.7	32	42.7	237	46.1	51.5	46.6-56.5
Missing	40	9.3	24	32.0	67	13.0		
Willingness to Use PrEP								
Very willing	230	53.7	34	45.3	267	51.9	61.2	56.5-66.0
Moderately willing	43	10.0	5	6.7	48	9.3	9.7	5.9-13.5
Somewhat willing	41	9.6	5	6.7	46	8.9	11.6	6.9-16.3
Not willing	68	15.9	7	9.3	79	15.4	17.5	13.2-21.8
Missing	46	10.7	24	32.0	74	14.4		
Where Participant Prefers to Get PrEP (multiple response)								
HIV care clinic	41	15.0	5	12.8	46	14.6	14.8	9.5-20.1
Health centre, NOT HIV care clinic	196	71.8	19	48.7	216	68.6	70.7	65.1-76.2
NGO or health department outreach	111	40.7	24	61.5	137	43.5	43.6	37.9-49.1
Peers	31	11.4	2	5.1	33	10.5	9.5	4.8-14.3
Other source	26	9.5	9	23.1	36	11.4	11.5	6.2-16.7

3.6 Coverage of HIV prevention programmes among key populations

- Behaviour Change Prevention Programmes

Significant progress was achieved in reaching key populations through targeted community interventions (TCI). As an intervention, TCI manifested through group or individual discussions, workshops, through PLACE sites and other non-traditional settings. At its basic level, TCI involves STI risk assessment, VCT history, condom demonstration and strengthening the ability to negotiate condom use, conveying basic HIV facts and the ability to identify myths about HIV. Persons who are reached are consistently referred for VCT and STI testing.

In 2019, an increasing number of key populations were reached through targeted interventions. Ten thousand, six hundred and fifty-three (10,653) Female Sex Workers were reached, while 3,443 and 274 MSM and TG persons were reached respectively. Collectively, 14,923 Youth and Out-of-School Youths (OSY) were reached with HIV risk reduction information. One region in the country disaggregated their TCI reached data to include adolescents aged 15-19 years. For that region, 10,768 adolescents aged 15-19 years were reached with HIV risk reduction information.

Across the country, a number of interventions were implemented to reach key populations with risk reduction information and skills building through empowerment workshops and summer camps. Newer interventions included partnership with places of safety to reach children in government funded homes, men's health interventions, hold on hold off interventions reaching youth in school and out-of-school settings, and gender-based violence workshops supporting FSW.

Additionally, Behaviour Change Communication (BCC) teams supported the national effort to identify key populations, not previously known, for referral to VCT and STI testing and connection to support services and treatment care and support. Working within TCI, BCC teams facilitated over a dozen workshops, aimed at empowering key populations with tools to disclose sexual orientation and sexual practices. Variable successes were achieved across key populations, with FSW showing the most yield. In one region, 15 previously hidden FSW were identified through women's health workshops and community informants. However, the yield through men's health workshops and community informants for identifying new MSM and TG populations was negligible.

Successes in HIV Prevention Programmes among Key Populations:

1. Improved visibility and development of stronger relationships between key populations and prevention staff. The Staff has been immersed in high impact trainings and understanding the levels of stigma and discrimination experienced by key populations. This has forged greater collaboration with key populations and civil society organizations. Greater consultations and involvement in site-

level programmes have been experienced between government and CSOs empowering key populations.

2. At the regional level, government has implemented a Peer Link programme, which creates linkage between patient and treatment site. Peer Links are hired by government as contracted workers and are an extension of the treatment, care and support teams. Peer Links are members of the key populations who are identified as influencers. Influencers are identified through TCI workshops and or known and respected KPs. Their primary role is to reach MSM and TG for sexual and reproductive health (SRH) services, to connect KPs to testing services and to engage persons in empowerment workshops and skills building activities.
3. Previously, the country reported improved efforts in estimating and procuring adequate number of rapid test kits. Additionally, improving the supply chain management remained a priority of the national programme. For 2019, outreach teams reported no stock out of rapid test kits during the period, which enabled all populations unfiltered access to getting STI and HIV tests. The result was an achievement of 58,357 rapid HIV and 57,043 STI tests done during the reporting period.

Challenges in HIV Prevention Programmes among Key Populations:

1. Stigma and discrimination strongly influence disclosure among key populations, specifically, MSM and TG persons. Although increased skills-building among health care workers has taken place, greater collaboration among key stakeholder groups, government and civil society organizations, and increased investment to create friendlier health care settings for key populations have all resulted in greater reach among MSM and TG persons, the vast majority of persons are still not reached. BCC teams believe that more tailored information about MSM and TG persons that addresses their vulnerability, guided self-care practices and the role of the health care system in achieving the goal of maintain optimal sexual and reductive health is needed. Creation of such IEC materials will empower key populations with information to help them make better decisions about their health and improve their health seeking behaviours.

2. Jamaica, in 2019, experienced a sharp increase in the number of crimes. In response, the government instituted emergency protocols in different parts of the country. Referred to as Zones of Special Operations, the security forces were given the authority to search, seize and detain people of interest within the designated geographic locations. Additionally, curfews were mandated, resulting in early closure and or temporary closing of business places such as restaurants, supermarkets, bars and night clubs. The impact on TCIs in high impact communities was significant. Key populations were displaced from traditional settings, reducing the interaction between BCC teams and key populations.

3.7 Condoms distributed – 5-6 million condoms and lubricants

- Condom Quantification Exercise

In early 2019, Jamaica engaged key experts in a consultative process to conduct a condom quantification exercise. The exercise focused on strengthening access to condoms among all populations, particularly among the key populations. The goal of the exercise was to ensure that through the development of national targets, the HIV/STI/Tb programme would eliminate future condom shortages and stock-outs.

Table 8 presents the calculation used in determining the national condom estimation for all populations including for key populations. Although youth, a vulnerable population is not specifically noted in the condom quantification exercise, they would be accounted for in each of the sub-populations. This is an area of weakness that is acutely noted in programming exercises and which requires strengthening. In 2019, 18,741,600 condoms were forecasted to support effective HIV prevention programming, increased condom use among key populations and increased condom use during high risk sex acts.

Table 8: Condom Quantification Exercise, 2019

Population	National Population Target	Average Number of Sex Acts per Year	Total Number of Condoms Needed

General population	30,000	3x4x12 = 144	30,000x144 = 4,320,000
MSM	14,000	5x4x12 = 240	14,000x240 = 3,360,000
TG	4,000	5x4x12 = 240	4,000x240 = 960,000
FSW	11,500	15x4x12 = 720	11,500x720 = 8,280,000
PLHIV Retained in Care	12,650	3x4x12 = 144	12,650x144 = 1,821,600
Total Number of Condoms Needed			**18,741,600**

3.8 Condoms & Lubricants Distributed

Table 9 shows the distribution of condoms and lubricants across the regions in 2019. Collectively, 1,108,800 condoms were distributed in the country, while 58,375 lubricants were distributed. Efforts to effectively monitoring the distribution chain of condoms and lubricants is actively being perused to ensure accurate reporting for condom distribution among key and vulnerable populations.

Table 9: Condoms & Lubricants Distributed Across Regions

CONDOM AND LUBES DISTRIBUTION

MONTH	SRHA		NERHA		WRHA		SERHA	
	CONDOM	LUBES	CONDOM	LUBES	CONDOM	LUBES	CONDOM	LUBES
JANUARY	9624	457	16249	629	15307	248	19946	508
FEBRUARY	17048	537	19148	385	14857	598		385
MARCH	17240	549	8164	336	23925	361	26488	212
APRIL			13,485		17297	738	41616	2237
MAY	16624	364	17424	88	22547	1341	44209	2201
JUNE	19358	487	15146	1851	20904	886	42032	2481
JULY	22546	893	17381	336	22339	613	35397	1914
AUGUST	22653	1309	6,100	184	27768	1045	36410	2209
SEPTEMBER	20442	1724	19086	1984	36585			
OCTOBER	16406	1665	30,471	6,100	33581		44044	2091
NOVEMBER	28758	2488	26,071	4,345	35784	499	34980	3029
DECEMBER	26019	3251	52,926	8,480	27314		27161	2027
TOTAL	216718	13724	241651	24718	298208	6329	352283	19294

COMMITMENT 4: Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020

4.1 Discriminatory attitudes towards people living with HIV

Referencing the Second Latin American and Caribbean Forum for the Continuum of HIV Care was held in Rio de Janeiro, Brazil, in 2015, although data is not available to report on the LAC indicators, Jamaica, driven by civil society and supported by government, provides an indication on the country's progress towards achieving zero discrimination.

- Anti-Stigma TV Commercial

The Ministry of Health and Wellness, led by Honourable Christopher Tufton, Minister of Health and Wellness, disseminated unequivocal messages to stop stigma and discrimination for people living with HIV. In Jamaica, stigma and discrimination persists as barriers to access healthcare, specifically for HIV testing and accessing treatment and care. According to the 2017 KABP, young people were least likely to have accepting attitudes towards people living with HIV.

Hon. Christopher Tufton, Minister of Health and Wellness, and Actress, Jordon Spencer, on set filming the Anti-Stigma advertisement, 2019

The television commercial featuring the Minister of Health and Wellness and Actress Jordan Spencer sent a clear reminder of how HIV is spread and appealed to Jamaicans to end stigma and discrimination.

Train and Sensitize Non-medical Health Care Staff

Over the past 10 years, health care workers, specifically medical staff have been a priority population for which messages, interventions and programmes were designed to reduce high levels of stigma and discrimination experienced by PLHIV and key populations in health care settings. With reference to several programmatic reports (included in the reference section), tangible gains have been achieved among this cohort of health care staff. Although interventions remained focused on medical care teams, greater attention has shifted to non-medical staff in the health care settings to ensure safe spaces for PLHIV and key populations.

Ensuring that country-wide sensitization and training of medical and non-medical staff in human rights-based approaches are integrated in health service delivery in order to end discrimination and limited access to care by vulnerable and key populations remains a health sector priority. During 2019, both government agencies and civil society organizations played their respective roles in reaching health sector employees at treatment sites.

- Health care workers sensitised in human rights to improve their service delivery – CSO Interventions

Jamaica AIDS Support for Life (JASL) conducted four training sessions among 91 healthcare providers across all four regions, which included doctors, nurses, and pharmacists within both the public and private sector. Sessions focussed on integrating human rights approaches to service provision and delivery. During the training, HCWs were given a task to draft their personal code of conduct regarding integrating human rights in how they deliver care.

The pre- and post-tests done by JASL included knowledge-based questions on HIV virology and institutional code of ethics, as well as attitudinal based questions. Findings from the pre and post tests show that:

- over 90% of healthcare providers believed that human rights are generally afforded to all persons, irrespective of status;
- Over 40% of HCWs believed that PLHIV should be treated separately from other patients to prevent the possibility of transmission. Post-tests showed a 20% reduction in those agreeing with the statement;
- There were significant knowledge gaps relating to universal precautions and specific virology concepts expected of medical professionals. Post tests showed improved knowledge.
- Significant levels of institutional stigma such as selective use of universal precautions and observed breaches of confidentiality by non-medical personnel exist.

- Train non-medical health care staff: clerks, receptionists, administrators and Security guards to respect and promote the human rights of PLHIV and KPs accessing services – Government Interventions

Through the support from the Global Fund and Ministry of Health and Wellness, the National Family Planning Board, facilitated 4 regional workshops reaching 111 non-medical staff. The workshops were intended to build the capacity of non-medical health care workers to reduce stigma and discrimination and improve awareness of and adherence to human rights principles.

The workshops awakened the realization that all staff in health care settings have a role in creating safe spaces for PLHIV. Categories of staff present during these workshops were Security Officers, Patient Affairs Officers, Hospital Administrators, Health Record Administrators, Health Records Clerks/Health Information Technicians, Cashiers and Customer Service Officers, Male and Female Attendants, Hospital and Clinic Attendants, Community Health Aides, Hospital Attendants, Laboratory Assistants, Receptionists, Leave and Benefit Officers, Accounting Clerks, Epi Clerks, Secretaries, Telephone Operators, Human Resources Assistants and Drivers.

A standard number of topics were covered in each workshop. Topics included confidentiality, human rights and Human rights-based approach to health care delivery, personal values and self-awareness, clarifying HIV/AIDS related concepts; compassion and quality service delivery, stigma, discrimination and diversity, HIV-related stigma and discrimination and showing respect for PLHIV and key populations. Additionally, the MOH Complaint Management System, its utilisation and reporting process was a topic included in the workshop.

Community Advocacy Addressing Gender-based Violence, Social Protection, Stigma & Discrimination

Changing negative conversations, behaviours and attitudes toward vulnerable and key populations is paramount to achieving improved health outcomes. Through the tireless work of government, development partners, and implementing agencies support to reduce stigma among the general population and build the policy and legislative

landscape for anti-discriminatory policies and legislations is at high levels. A number of interventions were implemented in the reporting period that reflect government and civil society advances to address and increase awareness of GBV, human rights and stigma and discrimination.

- Rispek Tour & 16 Days of Activism

A massive national effort was coordinated by the National Family Planning Board bringing together 25 multisectoral partners spanning, government, regional health authorities, agriculture, insurance, social services, women empowerment, legal, financial and civil society organizations representing PLHIV and human rights. These all joined a national road tour. The primary aim of the road tour was to integrate and inform dialogue about gender-based violence, stigma and discrimination and human rights and violations that perpetuate a culture of abuse and violence.

Figure 3: The Legal Aid Council at Rispek Tour, 2019

Aptly titled the "Rispek Tour" (utilizing the Jamaican Patois language for Respect), the tour utilised the community fair model in engaging community members in 8 rural and urban communities across Jamaica between August and November 2019.

Figure 3 provides a visual presentation of a service provider at the Rispek Tour. Impressively, almost 800 people visited and engaged with partner booths for broad service level information. Equally impressive, was the supportive social media

campaigns that resulted in over 41,000 and 57,000 engagements and views. Video highlights of the Rispek Tour 2019 can be view from the following NFPB YouTube link: https://youtu.be/-ZJA5IdpNR4.

The Rispek Tour culminated at the Human Rights Day observance event on December 10, 2019. This event ended the 16 Days of Activism, which started on 25 November, involved multisectoral stakeholders, most of whom participated in the Rispek Tour.

Programme activities included (i) facts on gender-based violence (GBV), (ii) polls on human rights and GBV, (iii) a newspaper article on human rights published by the Daily Gleaner on Friday, 13 December (Appendix A) and (iv) social media prizes of mobile phone cards for correct answers.

Figure 4: Rispek Tour, Certificate of Participation

During the Human Rights Day observance event, certificates of participation was provided to all agencies and organizations who participated in the Rispek Tour (refer to Figure 4). Recognizing the significant investment of time by all partners, their resources and their consistent effort to attend all 8 tours, there was no disputing that their dedication was tremendous in achieving a successful Rispek Tour.

❖ Sensitization CSOs on Social Protection Issues

Within the Ministry of Labour and Social Security, the HIV Unit coordinated and facilitated the sensitization of PLHIVs through their respective support groups, convened within civil society organizations, namely JASL, JCW+ and JN+. The sessions focused on services offered by the Programme of Advancement through Health and Education (PATH) and the Public Assistance Department of the Ministry of Labour & Social Security. Participants were educated on what was available through the programme and how they can be accessed. During these sessions with people living with HIV, applications for grants and benefits were facilitated.

Major MLSS accomplishments in 2019:

1. Development of a three (3) year plan **for Addressing HIV and AIDS based on employment, labour laws/policies and anti-discrimination strategies that affect workers.** The plan seeks to reduce HIV-related stigma and discrimination (S&D) by engaging individuals who are involved in processing complaints and facilitating redress including workers' representatives and employers.

2. One hundred and thirty (130) Labour Officers from the Ministry's head and parish offices were engaged in a series of capacity strengthening workshops. The focus of these workshops was to ensure that "Due Process in Dispute Resolutions" is instituted when addressing cases of unjustifiable dismissals in the context of real or perceived positive HIV status.

3. Forty-one (41) Trade Union and worker's representatives were trained to provide technical support to workers in accessing and navigating grievance procedures and redress mechanisms relating to HIV-related workplace discrimination. These activities were carried out in collaboration with NFPB, JASL, JEF and JN+.

4. Twenty-eight (28) companies engaged in discussion about HIV in the workplace. MLSS and JN+ collaborated to widen the reach of employers across the country.

5. MLSS/HIV Unit secured a major win for civil society treatment sites. The team obtained Ministry of Labour & Social Security recognition for JASL Clinics, a civil society organization providing treatment to PLHIV, as legitimate HIV/AIDS treatment centres. This was germane to the Ministry accepting medical reports for HIV/AIDS patients as part of the PATH enrollment appeals process.

❖ <u>FBOs engaged and referral directory updated for use by all HIV services health partner</u>

The referral protocol was amended concomitant to revisions made to the Memorandum of Agreement as per recommendations from the Attorney General's Department and the MOHW Legal Services Unit. The referral directory and protocol will serve to strengthen and formalise the relationship between regional health authorities, ministries, departments and agencies (MDAs), civil society organisations (CSOs) including faith-based organisations (FBOs) to increase access to social protection services for clients of public health care facilities. Accordingly, NFPB sought to scale up the partnership with the Ministry of Labour and Social Security (MLSS) to strengthen the social protection mechanism in particular at the public interface through the MLSS case workers to address needs and concerns of vulnerable populations in the context of Sexual and reproductive health, including Family Planning and sexually transmitted infections. The Referral Directory will also be printed and distributed to religious sector health and family life case managers, social workers and HIV programme managers in the RHAs.

❖ <u>Sensitization of Faith-based Organizations' Leaders, Congregants & Community Leaders</u>

In an effort to change the general attitude towards PLHIV and KP, targeted interventions with faith-based leaders and their congregants were implemented. Led by the Jamaica Council of Churches, the activity engaged three religious site facilitators with

participating churches. The site facilitators were instrumental in mobilization and sensitization sessions with 31 religious ministry leaders including clergy, with a total 163 participants representing 18 churches reached at the mobilization sessions (Figure 5). The sessions focused on HIV basics, human rights, stigma and discrimination, practical ways of integrating these messages in sermons/liturgies and bible studies.

Figure 5: Ainsley Reid, GIPA Coordinator meetings with Jamaica Council of Churches

Data received from the Jamaica Anti-Discrimination System (JADS) was used to identify communities in which higher proportion of stigma and discrimination and human rights violations were experienced by PLHIV and key populations. the NFPB in collaboration with JN+ partnered with the Social Development Commission to identify community leaders in these respective high complaint burdened communities. Twenty-one (21) community leaders were trained on issues of human rights violations, stigma and discrimination reduction interventions, how to treat with PLHIV and diversity in the community setting, complaint and referral mechanisms, conflict resolution and HIV basic facts. An outcome of the training was the developed action plans for mobilizing and sensitizing other key members of their communities, integrate HIV-related stigma and discrimination issues in community events and make referrals. Future reported human rights violations should be monitored against these communities to determine medium term goals and long-term impact of these interventions.

Policy and Legislative Framework

There was rich policy discourse in 2019. Quite a number of policy research papers on human rights, anti-discrimination and HIV were drafted, and/or legislations and policies were either reviewed or the process was continued during the reporting year.

- Anti-discrimination Policy Research Paper and Advocacy Strategies

Development of a Policy Research Paper around a proposed Anti-Discrimination Legislation is currently being led by Jamaica AIDS Support for Life (JASL). The Office of the Public Defender is engaged as co-chair of the multi-stakeholder technical working group to provide guidance and oversight, while ensuring government ownership, buy-in and advocacy for legislative adoption. National consultative exercises have started at the community level and across multi-sector stakeholders to ensure broad citizen involvement and feedback. It is anticipated that the final policy research paper and draft ant-discrimination bill will be finalized and disseminated by June 2020.

- Review of the Health-related Recommendations of the Joint Select Committee (JSC) Report

Background

In 2019, the National Family Planning Board reviewed the Joint Select Committee Report, giving keen attention to all areas with health-related implications. As a background to the process, the Joint Select Committee of Parliament, which was appointed to review the Sexual Offences Act, the Offence Against the Person Act, the Domestic Violence Act and the Child Care and Protection Act published its report in December 2018.

The following outlines the JSC recommendation on intentional and reckless transmission of HIV including the main response of the NFPB through its Position Paper on the matter which the Minister of Justice subsequently positively referenced in the

Lower House of Parliament. A Cabinet Submission requesting the tabling of the Position Paper in Parliament is anticipated to be made.

The Committee recommended that the Offences Against the Person Act should be amended to make it a criminal offence for someone to 'wilfully or recklessly infect a partner with any sexually transmissible disease that can inflict serious bodily harm to that partner.' In other words, the Committee recommended that a specific criminal law be enacted to deal with instances of intentional transmission and reckless transmission. The Committee expressed that there was a deficiency in the law concerning the deliberate or intentional spreading of HIV and other sexually transmitted diseases and noted that this type of offence existed in the United Kingdom and Canada.

National Family Planning Board Summary Position:

1. There is no need for an HIV-specific criminal law to prosecute the intentional or reckless transmission of HIV because Jamaica already has a general criminal law in sections 20 and 22 of the Offences Against the Person Act that can be used to respectively prosecute intentional and reckless transmission of HIV and any other sexual infection. Consequently, Jamaica's general criminal law already provides a remedy for anyone who believes that a wrong has been committed against them in this regard. Further Jamaica's general criminal law operates in similar ways as the general criminal laws of the United Kingdom and Canada to which the Committee refers. Neither the United Kingdom nor Canada has an HIV- specific criminal law to prosecute intentional or reckless transmission of HIV and other sexual infections. Both jurisdictions, as does Jamaica, rely on their general criminal laws.

2. Enacting an HIV-specific criminal law does more harm than good – it will be harmful to the national HIV response and is likely to have other unintended consequences. The Government of Jamaica must be prepared for a huge international blowback. This conclusion is arrived at in light of the context within which the Government of Jamaica is now considering to enact an HIV-specific criminal law. In 2019, the Government of Jamaica has the benefit of information on the latest scientific advances in the treatment of HIV, of international guidelines and standards regarding

the criminalisation of HIV and the treatment of people living with HIV, and of witnessing the global and regional movements against HIV criminalisation and HIV-specific criminal laws. The Government of Jamaica also has access to evidence from studies and from the experience in some jurisdictions which indicates that an HIV-specific criminal law contributes to the stigmatisation of people living with HIV and heightens the climate of fear surrounding HIV.

3. **Any concern about the application of the general criminal law can be remedied.** If there are concerns about the application of the general criminal law to prosecute intentional and reckless transmission of HIV and other sexual infections, this can be remedied with the careful and effective use of comprehensive prosecutorial and investigative guidelines.

- Policy Research Paper on Human Rights Commission

The draft Policy Research Paper on the Human Rights Commission developed by Jamaicans for Justice is completed. The aim is through advocacy, support the access to justice and legal options such as the legal aid system for key populations. Next steps in the process, involves the convening of a validation meeting scheduled for February 2020 among key civil society and other critical stakeholders and a planned multi-stakeholder media ad launch tentatively scheduled for April 2020.

- Revision of National HIV/AIDS Policy

The National HIV/AIDS Policy was last updated in 2017. Although, fairly recent, a number of strategic legislative and policy changes have occurred that has dated the document. Initial emergent issues for reflection in the updated policy will include:

- The introduction of Pre-Exposure Prophylaxis (PrEP) as part of treatment and care services in the public health delivery system
- Development of a new National Strategic Plan (NSP) to govern the national SRH response over the next five years, 2020-2025
- Operationalisation of the Human Rights Baseline Assessment Monitoring Framework and

- Recommendations of the Report of the Joint Select Committee (JSC) to Review the Sexual Offences Act (SOA) and related Acts that are pertinent to the national response and which was approved by Parliament on 5 November 2019.

Procurement services for this consultancy started in 2019 with an anticipated commencement timeframe in the second week of January and end by 31 March 2020.

- Promotion of Patients' Rights in Maternal, Neonatal and Infant Health (MNIH) in Jamaica

The National Family Planning Board, in partnership with Women's Resource and Outreach Centre (WROC) and the University of the West Indies embarked on an initiative to advance the promotion of Patients' Rights in Maternal, Neonatal and Infant Health in Jamaica (MNIH). The MNIH project is a component of the Programme for the Reduction of Maternal and Child Mortality (PROMAC), an intervention funded by the European Union (EU). The partnership is advocating for, among other things, for the establishment of a formal mechanism for ongoing collaboration between the MOHW, RHAs and Civil Society Organisations on matters related to MNIH policy and other issues.

Additionally, advocacy dialogues with regional health bodies for the improvement of the complaints and redress system was a featured activity. Presently, there are 4 distinct Patient Charter of Rights and Responsibilities for each region. Furthermore, to compound the situation, ineffective monitoring modalities exists, which hinders effective monitoring of the 4 charters. To ensure one standard of care and service delivery is attained by all patients, a single governing Human Rights in Patients' Care Charter is being proposed. A draft Human Rights in Patients' Care Charter has been developed for consideration across the 4 regional health authorities.

- Positive Health Dignity and Prevention (PHDP) Framework and PHDP Strategic Plan Launched

In an effort to more tangible reflect Greater Involvement of People Living with HIV/AIDS (GIPA) in the inception, development, implementation, monitoring and evaluation of

policies and programmes, Jamaica in 2019 launched the Positive Health Dignity and Prevention (PHDP) Framework and PHDP Strategic Plan.

Attended by the Minister of Health and Wellness who publicly endorsed the framework for coordinated leadership and greater engagement of infected and affected communities to HIV in the national response. Eighty-three (83) persons from 19 different civil and public entities attended the event. Additionally, commitment was secured from the Planning Institute of Jamaica (PIOJ) for strong advocacy to achieve the integration of the goals and strategic objectives into upcoming development agenda.

Globally, the PHDP is a recognized approach (led by Global Network of People Living with HIV - GNP+ and UNAIDS) that places the person living with HIV at the centre of managing his or her own health and wellbeing. It is a model which links HIV treatment, prevention, support, and care issues within a human rights framework.

The work of the GIPA Sub-Unit in the Enabling Environment and Human Rights Unit, is aligned with the mandate of the NFPB's strategic priority #3: Enabling Environment and Human Rights, encapsulated in the National Integrated Strategic Plan for Sexual and Reproductive Health (2014-2019). The main outcome for this priority area is a strengthened policy and legal framework for sexual and reproductive health and HIV prevention, treatment and care services supported by the six related outputs, particularly, capacity development for marginalized persons, including key populations and PLHIVs. The NFPB is committed to the protection and promotion of human rights which is critical to the achievement of positive sexual and reproductive health, and ultimately the national outcome of a healthy and stable population. USAID has partnered with the programme to fund the activities through March 2019.

The objectives of the launch are to:

1. Articulate the main PHDP priorities and strategies for community leaders, civil society/nongovernmental organizations, implementing development partners, and other Ministry, Department and Agency stakeholders;

2. To recommend appropriate actions to ensure efficient, effective performance of PLHIV community systems.
3. Consult with stakeholders on the plan of action to address issues of the HIV response pertinent to advance the GIPA Principle and the impactful participation of PLHIV as resources;
4. Consult with stakeholders on need for a mechanism to coordinate, monitor and evaluate implementation of PHDP priorities.

4.2 Avoidance of health care among key populations because of stigma and discrimination (A–D)

Intersectionality between stigma and discrimination and access to health service continue to be a focus of research studies in Jamaica. Through The 876 Study, the Stigma Index 2.0 and the MSM Self-Stigma & MSM/Transgender Intracommunity Stigma Needs Assessment, these reports help to understand the environment in which key populations navigate, interpret and relate to the health care settings.

- ❖ The 876 Study: Integrated Biological and Behavioural Surveillance Survey with Population Size Estimation Among Men who have Sex with Men and Transgender Persons in Jamaica

Healthcare Utilization

The 876 Study found substantial proportions of MSM (31.7%) and TGW (38.2) did not access medical care in the last 12 months. The majority who did receive healthcare visited a public clinic or hospital (68.7% of MSM and 74.2% of TGW). Of those who sought care, difficulties in accessing care was reported by 14.2% of MSM and 24.2% of TGW.

Access to Services

A majority of MSM and TGW (75.2% and 73.5%, respectively) received HIV prevention information in the previous year. Interestingly, fewer were aware of any civil society or religious organizations that deliver non-medical services to the community (39.7% of

MSM and 56.9% of TGW). Attending meetings or programs related to HIV in the six months preceding the survey was reported by 48.8% of MSM and 62.7% of TGW. About one third of MSM (35.8%) and TGW (34.3%) had contact with a peer educator in the six months preceding the survey.

Stigma and Discrimination

The study reports that stigma and discrimination was manifested as refusal of services, and verbal, physical, and sexual violence due to MSM and TGW status, with multiple events common even within the last 12 months. These events were particularly frequent for TGW. The most common refusal of service for both populations was by the police (15.8% for MSM and 43.1% for TGW), followed by discrimination in housing (12.3% for MSM and 31.4% for TGW). Majorities of TGW (83.3%) and MSM (64.6%) experienced verbal abuse in the last 12 months. Additionally, almost half (46.1%) of TGW experienced physical violence, and 17.6% reporting sexual violence.

- ❖ Stigma Index 2.0

Funded by USAID, the Stigma Index 2.0 was completed in 2019 with overwhelming support from the community. 557 PLHIV responded to the survey, with 53% women, 38% men and 10% identified as transgender and nonbinary. Majority of the respondents were between the ages of 25 and 34 years, with equal distribution of respondents in both age groups of 35-44 and 45-54 years. 14% of respondents were accounted for in both the 18-24 and 55 and over age groups, respectively.

Thirty three percent (33%) of all respondents reported experiences of stigma and discrimination within the last 12 months outside of the healthcare setting. Supported by research, persons who have sold sex and transgender/nonbinary persons reported higher stigma and discrimination of any subpopulation group. Of all respondents, only 10% reported experiencing stigma and discrimination within the health care sector. This provides huge validation to the investment of resources by funders, civil society and government in reaching health care workers with HIV sensitive training.

Of 557 PLHIV in the study, 38% reported delaying their HIV test, while almost half of the sample (44%) reported delay in accessing treatment. Adherence remains a major concern, with 27% of PLHIV reporting missed ART doses.

- ❖ MSM self-stigma & MSM/Transgender Intracommunity Stigma Needs Assessment 2019

Similar findings of stigma and discrimination as reported by PLHIV in the Stigma Index Study 2.0. Access and delivery of health care services was positively reported by the 102 respondents. Although the study reported the ability of participants to recount incidents of stigma and poor service delivery in the health settings, most respondents were relatively happy with the service they received. Additionally, the report mentioned the renewed sense of resilience and empowered to demand better service from health care workers when it is lacking.

According to the report, the MSM and people of trans experience greatest fear was disclose of their sexual orientation or HIV status by health care workers. Although 82% believed that penalties for health care providers would be likely to prevent breaches of confidentiality, this remained an area of vulnerability and was of great concern.

Respondents from both the survey and focus groups mentioned the role of self and social stigma interference when attending scheduled check-ups. Additionally, respondents stated that hospital and clinic protocols made it difficult to keep their HIV and sexual orientation confidential. For MSM and people of trans experience, engagement with the health system jeopardizes their patient rights to confidentiality but the potential physical and emotional consequence of inadvertently or improper disclosure of the HIV status or their sexual orientation.

4.3 Prevalence of recent intimate partner violence

Integration of GBV in the health sector

- Regional Consultation Meetings Reviewing the existing Accident & Emergency Manual and Proposed Elements for GBV Integration

Jamaica continues to increase momentum towards universal access to quality and affordable sexual and reproductive health-care services, including HIV services, for women, other vulnerable populations and key populations. During the reporting period, Jamaica moved forward in finalizing the Clinical Care Guidelines for Sexual Assault, an initiative that has been hailed as timely.

The clinical practice guidelines targets doctors, nurses and social workers working in detection of interpersonal violence in healthcare practice. Primarily, the guidelines are intended to be used by core multidisciplinary health professional teams, who includes medical doctors, family nurse practitioners, registered nurses and social workers working in secondary and primary health care settings. The document provides guidance for the detection and management of persons affected by interpersonal violence using the minimum standards of care. Health care providers will perform critical roles in the prevention, early detection, response to disclosures of interpersonal violence, and follow-up and support of persons experiencing adverse health effects using recommendations for the minimum standards of care.

WHO does encourage healthcare providers to raise the topic with women who have injuries or conditions that they suspect may be related to experience(s) of violence. Moreover, the clinical care guidelines will also facilitate the groups screened to include children, young people, adults, persons with disability (physical, mental) and the elderly, commercial sex workers, MSM, persons in institutional care and any person, on suspicion of experiencing sexual assault.

Importantly, the key clinical issues to be covered include: (i) early detection and clinical management; (ii) psychosocial support; and (iii) legal issues.
The main objectives of managing persons affected by interpersonal violence are:

1. To prevent further abuse

2. To create a safe space/supportive environment where the client can discuss the abuse

3. To enable the multidisciplinary team to collect relevant information to make a diagnosis and prescribe/recommend appropriate interventions and care.

4.4 Experience of HIV-related stigma and discrimination in the healthcare setting

Community Monitoring of Stigma and Discrimination

- Jamaica Anti-Discrimination System (JADS)

The Jamaica Anti-Discrimination System is a mechanism that allows for the collection of complaints from people living with HIV and other vulnerable groups and key populations. The main outcome of the reporting mechanism is to provide redress to all persons reporting discriminatory offences. Outlined in the protocol when making a complaint and seeking redress involves submission of a confidential complaint report; interview with assigned redress officer; a thorough case investigation; and finally, a process of redress intervention.

During the period of January 2019 – December 2019, a total of 46 cases were collected and reported to the Jamaican Network of Seropositives (JN+). It is important to note that are high levels of under reporting of discriminatory practices in Jamaica. Certainly, JADS Officers are trusted with hearing a greater number of incidents of discrimination, however, because of fear, only 46 cases were officially reported.

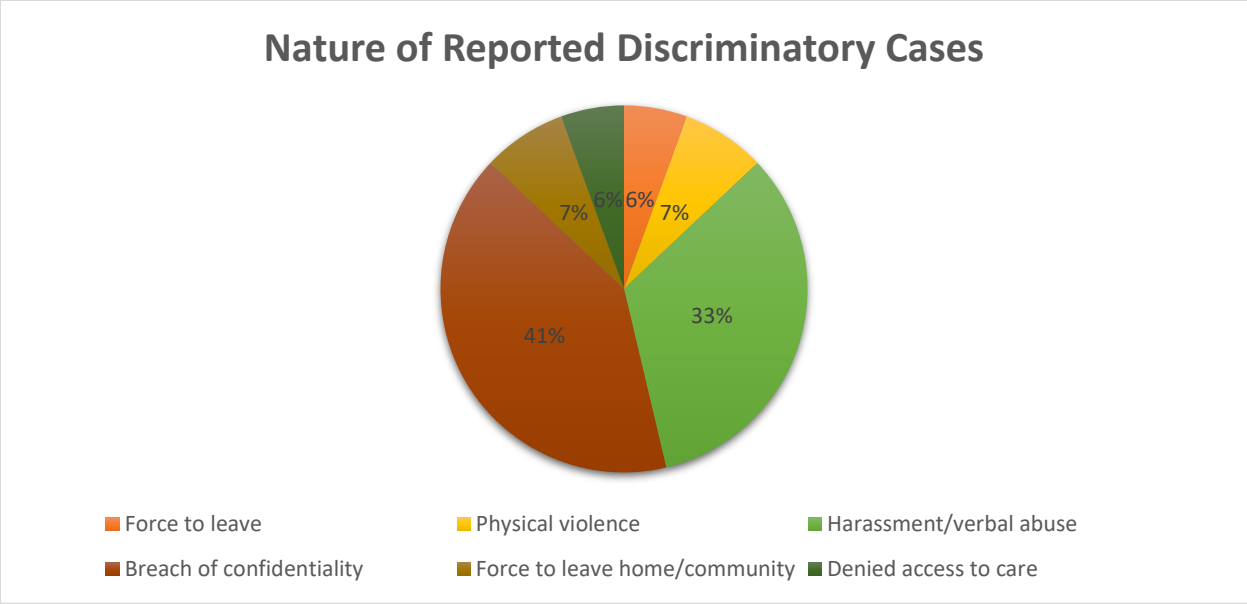
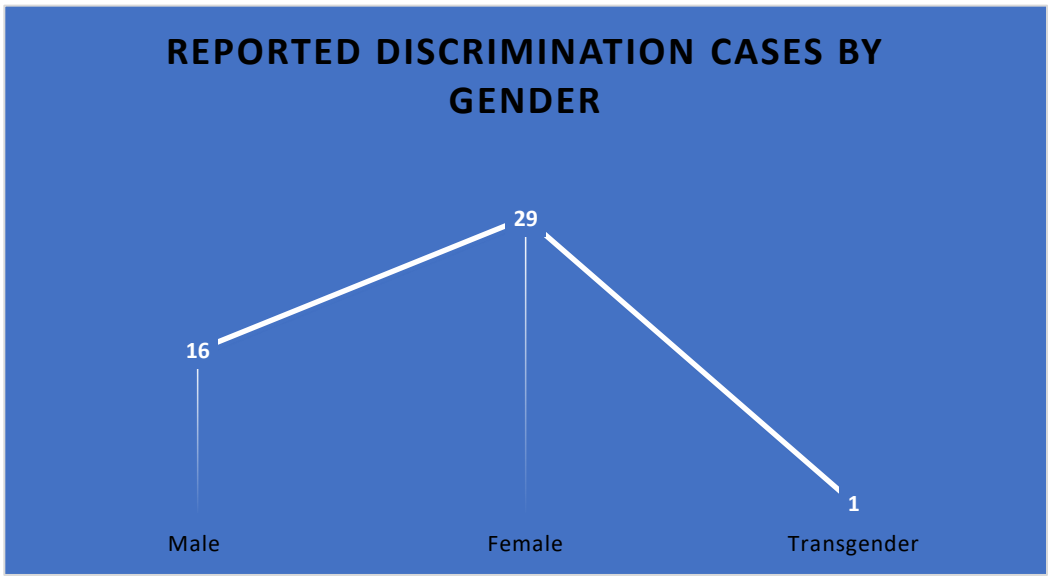


Figure 6: Nature of Reported Discriminatory Cases

Of the 46 cases, the nature of incidents reported were documented as, forced to leave job, physical violence, harassment/verbal abuse, breach of confidentiality, force to leave home/community, and denied access to care (Figure 6). Although were 46 reported cases, several persons reported multiple violations concurrently, resulting in 54 incidents of reported discrimination.

Figure 7: Reported Discrimination Cases by Gender

Similarly, Figures and 8 respectively show the distribution of reported cases by gender and parish.



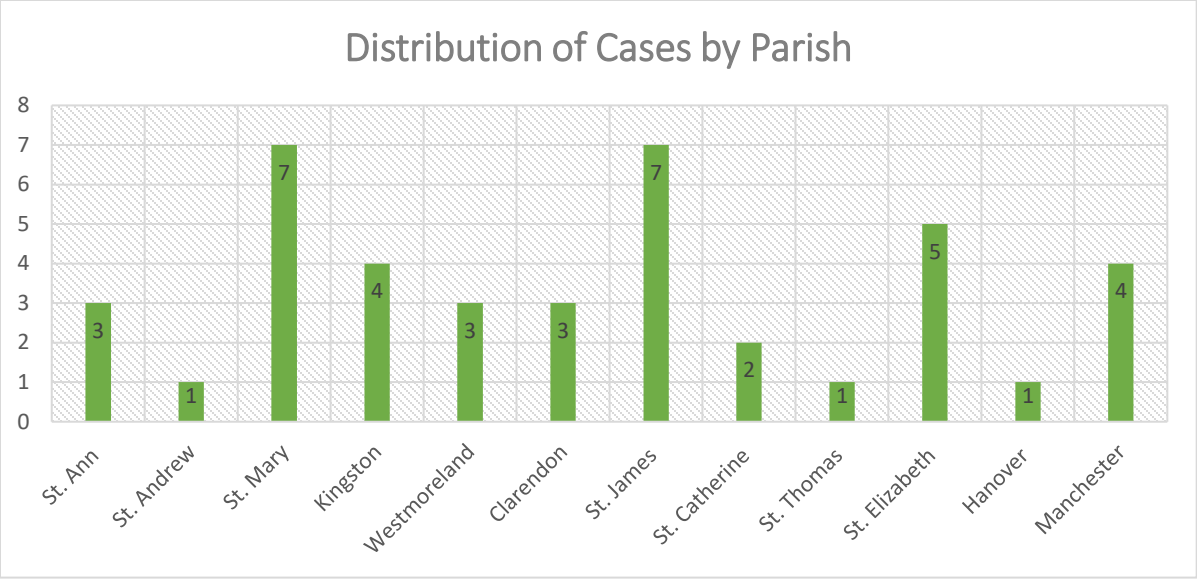


Figure 8: Reported Discrimination Cases by Parish

For additional insights into the type of cases being reported through JADS, refer to the two reported cases presented in Appendix B.

❖ Stigma reduction campaigns and IEC materials promoting tolerance and respect developed and implemented

The Jamaica Network of Seropositives (JN+) developed the “JADS Journey with JADE.” It is character-based illustrations (Pictured) that flags discrimination as a human rights violation. The primary goal of the media campaign is to promote the utilization of the Jamaica Anti-Discrimination Systems (JADS), facilitated by direct linkage of PLHIV with JADS redress officers. This media campaign has expanded to social media platforms that includes twitter, Instagram and Facebook.

❖ Mystery Shopping to improve monitoring of violations

Ten (10) KP members were trained as Mystery Clients and 30 mystery assessments were conducted at treatment sites in the South East Health Region. Seventy percent (70%) of shoppers felt that it was easy to get assistance at the sites they visited. Difficulty mentioned by the Mystery Clients reflected more on the general levels of service offered in the health sector rather than as a result of sexual orientation whether real or perceived. Consistently, medical staff (doctors and nurses) are viewed more favourably for their level of service and professionalism compared to non-medical staff such as security guards and reception personnel. The findings indicate the need to scale up interventions targeting non-medical and frontline staff within the health facilities. Additional mystery shopping will continue in the upcoming year.

COMMITMENT 5: Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020, in order to reduce the number of new HIV infections among adolescent girls and young women to below 100 000 per year

5.1 Young people: Knowledge about HIV prevention

In 2019, social media was increasingly utilized as a health promotion tool by both civil society organizations and government agencies. Through “likes, clicks, comments, reposts” teams are monitoring programme level interventions to reach young people with relevant information to improve their skills and capacity as they make everyday decisions about their health.

- MSM Social Media Campaign

As a civil society, the ASHE Company, revamped their existing social media pages to provide more general information reaching young people. The team found that this strategy yielded higher results through their “TabsProject” on three popular platforms, Instagram, Twitter and Facebook. In an effort to grow engagements further, ASHE created videos and graphics under several campaigns; ‘Boots Camp’, ‘ART my vitamin C’, ‘Sex comes with responsibility’, ‘All Are Welcome’, ‘U=U’ and ‘Wheel and come again’. The various campaigns explored thematic areas such as sexual health, relationships, risky sexual practices, treatment adherence and viral suppression.

The adolescent and youth programme within the National HIV/STI programme has promulgated strong content on addressing issues faced by young people on social media. One such project was the #colourfullyproud (Figure 9) campaign supporting young MSM identity, dignity and prevention.

Figure 9: #Colourfullyproud - Young MSM Campaign

Focusing on young MSM, this campaign, under the slogan #colourfullyproud, developed materials for weekly advertising on Google, Facebook and Instagram. Topics covered include, condom and lubricant promotion, HIV testing and adherence to ARVs. Most followers are young males in the 15 to 24 age group. Followers also frequently asked questions about accessing HIV testing as well as condoms and lubricants. The social media campaign allowed the team to reach a wide cross section of MSM including those in rural communities and those constituting sections of the hidden population.

- Mass Media Campaigns

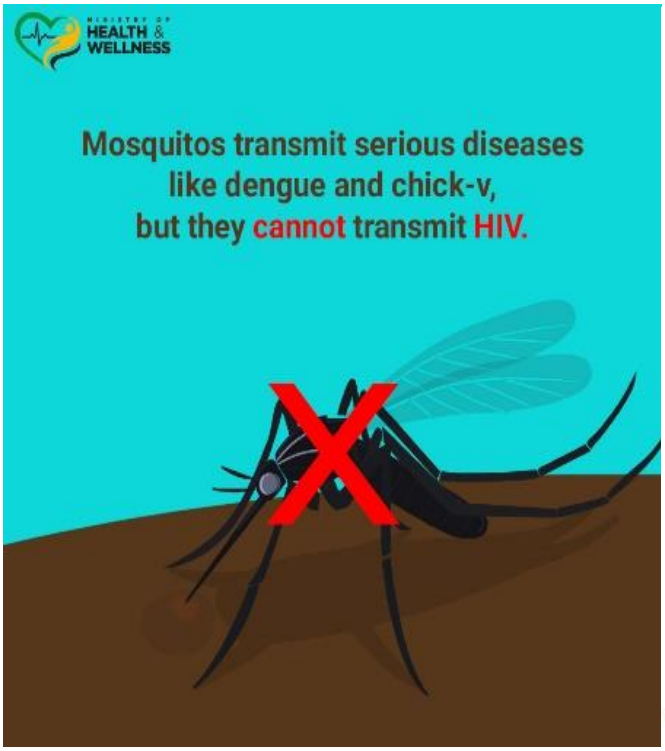
Condom promotion was heavily promoted in 2019. Whether on public transportation buses or on television radio and newspaper, discussion about condom use was widely pushed as a programme level intervention.

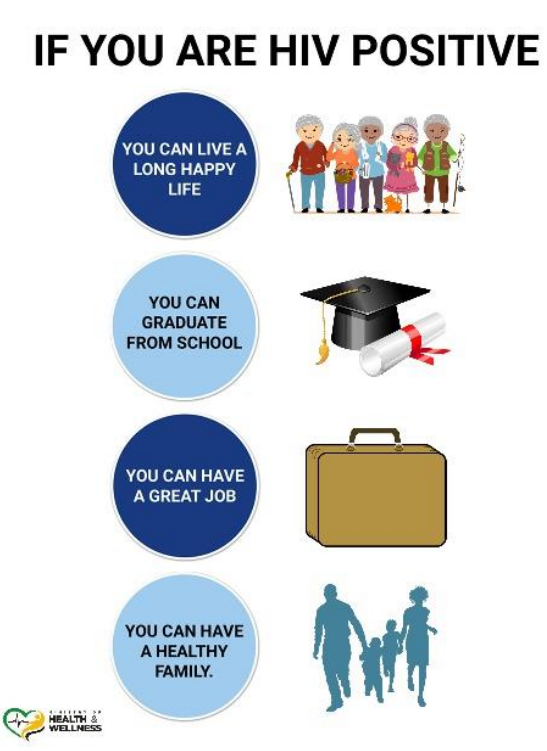
Referring to the Condom connect campaign (Pictured), more commonly being used is the Patois language used to reach Jamaicans.

“DWEET FI YUH BEST LIFE” speaks to using condoms is part of living your best life. Importantly, mass media campaigns are usually collaboration across partners. For this campaign, three agencies partnered in this campaign launch - Ministry of Health and Wellness, National Family Planning Board and the AIDS Healthcare Foundation (AHF), Jamaica.

The objective of the campaign was to promote condom use as an attractive and desirable option for practicing safe sex. Condom use is low among high-risk groups such as those with multiple partners and those engaged in transactional sex. The campaign features a television commercial and three radio advertisements. Electronic posters were also created for social media advertising.

Additionally, the Ministry of Health and Wellness, created infographics to further support online and social media educational and awareness efforts. Pictured below, are sampled infographics used to equip young people with skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services, in order to reduce the number of new HIV infections among adolescents and young people.





- In-School Adolescents – Hold-On Hold-Off Intervention

An estimated 3,200 in school adolescents reached through a soft launch of social media and branded materials in December 2019. Specifically, with regards to adolescent girls, the Hold-On-Hold-Off intervention programme, geared at encouraging students to Hold-On from sexual debut and Hold-Off if sexually active, increased enrollment to 11 secondary institutions across three (3) health regions in 2019. The intervention covered topics such as Basic Facts on HIV/STIs, Risky Sexual Practices and Risk Reduction, Family Planning Options, Building Healthy Relationships etc.

The National Family Planning Board, with financial support from the United Nations' Children Fund, continues to coordinate interventions to reduce the risk of HIV, STIs and early pregnancy among adolescent boys and girls in Jamaica. The project sought to build the capacity of health care workers, as well as create an enabling and support environment through the development of a HIV Testing and Counselling (HTC) Tool which will be used to strengthen the health workers' provision of adolescent friendly services. Additionally, in a bid to reinforce adolescent sexual reproductive health

messages, branded materials for social media platforms and print media were developed.

- Health Fairs at The Teen Hub

Using the Teen Hub space discussed in the previous report, the HIV/STI/TB programme in collaboration with the Family Health Unit of the Ministry of Health and Wellness hosts two health fairs in 2019. With primary focus on young people, the health fairs featured condom distribution, educational sessions, skills building and HIV testing. Entertainment was an important component in reaching youth and as Pictured below. The team did not disappoint in pulling crowds of young people.

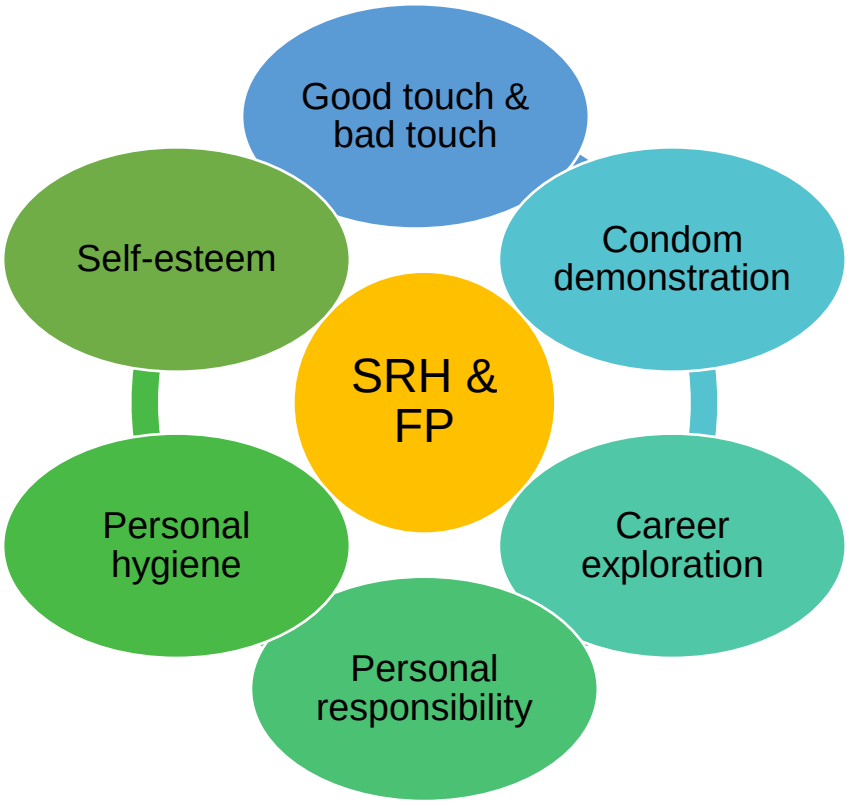
- Reaching Young People in Places of Safety

Partnership with the Child Protection and Family Services Agency (CPFSA) and the prevention programme of the National HIV/STI Programme have matured into a productive platform to reach adolescents aged 15 to 19 years who are in government supported places of safety.

During 2019, 309 young people were engaged in sexual and reproductive health and family planning interventions at boys' and girls' homes in urban and rural facilities

across the island. The BCC package of interventions includes activities highlighted in Figure 10.

Figure 10: Sexual and Reproductive Health & Family Planning Topics



It should be noted, that although condom discussions and demonstrations were done during these sessions, no condoms were distributed to young people. As a token for participating in the sessions, all participants received hygiene packages. Packages contained wash rags, soap, toothbrush, toothpaste, deodorant spray and roll-on, shampoo and conditioner, and sanitary napkins (for the girls).

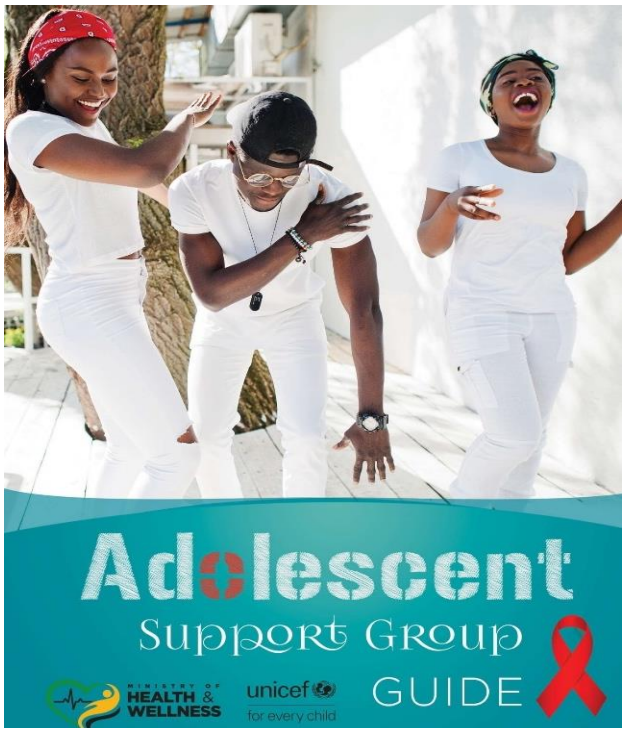
- ❖ <u>Empowerment programme for young key populations</u>

Regional youth Empowerment programmes were routinely held across the country. These sessions ranged from 1 week to 3-week activities and were packed with rich resources, discussion, skills building training in Microsoft Office applications, personal development topics including job interviews mock sessions. Altogether, 10 young MSM have been reached through this medium. Critical to these workshops were the involvement of social support agencies, through which linkages to employment

programmes were facilitated. Strong partnership with the National Youth Service (NYS) was forged. NYS representatives were able to introduce the job placement application to the young people and provided clear guidance for completing the application. Applications were submitted for job placement and participants are eagerly awaiting successful decisions for job placement and are hopeful about the future.

- Adolescent Support Group Guide

In Jamaica, through adolescent care services and adolescent-friendly clinics, Jamaica is demonstrating greater priority to this vulnerable population.



In collaboration with UNICEF, the Ministry of Health and Wellness developed the adolescent support group guide (Pictured) was aimed at standardising the delivery of educational and therapeutic group sessions with adolescents living with HIV (ALHIV) in all settings across Jamaica. Health care workers have been trained in the use of the guide and printed copies have been distributed to all Regional Health Authorities (RHAs).

5.2 Demand for family planning satisfied by modern methods

Jamaica, through its National Family Planning Board and giving authority through the Family Planning Act, 1970 is in the process of conducting a Reproductive Health Survey in 2020. The Survey will provide current data on major Sexual and Reproductive Health indicators such as contraceptive prevalence, which includes the demand for family planning satisfied by a modern method, fertility rate, and planning status of pregnancies etc.

In 2019, the public health system recorded approximately 22,647 (preliminary data) female demand for family planning that was satisfied by modern methods. Additionally, the Family Planning Programme reported a significant reduction in the number of contraceptive stockouts experienced at any primary healthcare facility across the country Contraceptive Logistics Management Information System Survey (CLMIS, 2019). This meant that more women had greater opportunities for access to desired family planning method through the public healthcare system.

- Reducing Teenage Pregnancy

The National Family Planning Board (NFPB) aided by a Grant (2017) from the Inter-American Development Bank (IDB) for project support in reducing Teenage Pregnancy executed with majority of the activities completed in 2019. The project sought to achieve an impact in seven (7) parishes, namely, Kingston and St. Andrew, Clarendon, St. Mary, St. James, Hanover, Westmoreland and St. Thomas. Cumulatively, these parishes account for over 75% of adolescent births in Jamaica.

Below are the objectives for the project and three components of the project:

1. To impact sexual and reproductive health behaviour change among adolescent boys and girls;
2. To increase public awareness of adolescent sexual and reproductive health (ASRH) issues, and;
3. To increase access to SRH services and commodities for adolescents.

Component one – Involved the production of an Adolescent Sexual and Reproductive Health training manual. This manual promoted the welfare of adolescents as they access services offered by healthcare facilities; empowering diverse staff employed to the facilities and foster an adolescent-friendly healthcare environment to support the delivery of quality health services to adolescents.

Component two – Training of adolescent intervention stakeholders using the manual developed in component one. The training engaged 60 adolescent stakeholders from selected health care facilities, the Ministry of Education and Women's Centre of Jamaica

Foundation in two phases. Each phase consisted of a 2-day training that covered two modules of the curriculum.

Component 3 – The administration of contraceptives to adolescent mothers as well as capacity building for medical practitioners, from both primary and secondary care facilities, in the insertion of Jadelle implants to expand the provision of service across the parishes. This exercise, which is ongoing and seeks to administer 300 Jadelle Implants, 200 Intra-uterine Contraceptive Device (IUCD) and 100 doses of Depo-Provera to adolescent mothers.

COMMITMENT 8: Ensure that HIV investments increase to US$ 26 billion by 2020, including a quarter for HIV prevention and 6% for social enablers

8.1 Domestic public budget for HIV

The government's commitment to ending AIDS in Jamaica is also demonstrated in its fiscal allocation for HIV and AIDS programmes from domestic public sources. Domestic resources have contributed significantly to the HIV funding landscape over the last decade.

For the period January to December 2019, Jamaica allocated 772,779,052.09 million Jamaican Dollars to HIV budgets (Table 10). Additionally, 325,107,368.54 million Jamaican Dollars was earmarked for key HIV programmes.

Table 10: Jamaica's Approved Budget for HIV/AIDS 2019

	Jan - Mar 2019	Apr - Dec 2019	Total
	JA$	**JA$**	**JA$**
8.1 Approved and executed public earmarked HIV budgets	240,324,324.09	532,454,728.00	772,779,052.09
8.2 Volume and prices of Antiretrovirals per regimen			
8.3 Total HIV expenditure by source and for key programmes	151,029,053.62	174,078,314.91	325,107,368.54

Domestic and international HIV expenditure by categories and funding sources			
8.3A Expenditure on HIV testing and counselling		63,258,583.00	63,258,583.00
8.3B Expenditure on antiretroviral therapy	84,216,526.38	86,952,768.52	171,169,294.90
8.3C Expenditure on HIV-specific laboratory monitoring	66,812,527.24	23,866,963.39	90,679,490.63

COMMITMENT 10: Commit to taking AIDS out of isolation through people-centred systems to improve universal health coverage, including treatment for tuberculosis, cervical cancer and hepatitis B and C

10.1 Co-management of tuberculosis and HIV treatment

Both the Clinical Management of HIV Disease and the National Guidelines for TB Management are currently being updated. According to these guidelines all patients living with HIV must be screened for TB at every visit and conversely, all TB patients must be tested for HIV. In the presence of active TB in a newly diagnosed person living with HIV (PLHIV), Antiretroviral Therapy (ART) is commenced between 2-8 weeks of anti-TB therapy.

All patients who have been diagnosed with active TB are hospitalized at the National Chest Hospital, Cornwall Regional Hospital or the Bustamante Hospital for Children. Active Pulmonary TB disease must be treated for at least six months with a two-month in-patient intensive phase and a four month out-patient ambulatory phase. The management of patients who are co-infected with HIV will be done in conjunction with the appropriate ART regimen.

10.2 Cervical cancer screening among women living with HIV

All women living with HIV are recommended to be screened for cervical cancer at least once yearly according to the Clinical Management of HIV Disease, 2017. A Pap Smear is one of the initial screening tests that is recommended for women diagnosed with HIV.

If the initial Pap Smear is negative it should be repeated six months after the initial test. If both Pap Smears are negative, then the patient can be screened annually.

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The 876 Study: Integrated Biological and Behavioural Surveillance Survey with Population Size Estimation Among Men who have Sex with Men and Transgender Persons in Jamaica, 2018-2019

Appendix A – Human Rights Are Not Gay Rights

Nicola Cousins | Human Rights Are Not Gay Rights

http://jamaica-gleaner.com/article/commentary/20191213/nicola-cousins-human-rights-are-not-gay-rights

Published: Friday | December 13, 2019 | 12:31 AM

It is safe to say that, in Jamaica, human rights seem to be synonymous with gay rights or are perceived as a euphemism for gay rights. The moment the words “human rights” are uttered in a conversation, it is seen as a gateway to the championing of the gay agenda. What exactly, then, are human rights? Could it be that if the citizens had an appreciation of human rights that there would be less crime?

To what extent do Jamaicans know their human rights and the accompanying responsibilities? Are human rights even being taught in schools and if no, why not? How then will we begin to understand what to expect of ourselves and the governing bodies of this nation?

With the advancement of technology, the world is evolving rapidly. Already, there is growing concern about how the increasing availability of artificial intelligence (AI) will affect access to work and our ability to earn an income. Similarly, as the world moves full speed ahead into a digital future, it necessitates dialogue about the digital divide and how best to address it.

The truth is, the rise of AI is a clear and present danger to a basic human right – the right to work. Likewise, with businesses becoming digital and moving away from brick and mortar structures to cyberspace, there is a compelling case for access to the Internet to become a fundamental human right. As such, the conversations have already started in this regard.

Foreseeing that AI could deprive humans of the right to work, countries have begun experimenting with the concept of the provision of a universal basic income (UBI), where individuals are given an amount of money each month as compensation for not being able to work and earn wages. If a person is not able to work, then it is highly likely that he/she will not be able to afford suitable housing, be able to buy food and have access to healthcare and will not be able to send his/her children to school in fulfilment of their right to an education.

As human rights are interrelated, interdependent and inalienable, whatever happens to one right directly affects all other rights and sets off a domino effect.

BASIC ENTITLEMENTS OF EVERY HUMAN BEING

It was deliberate that what essentially is a conversation about basic human rights began the way it did with a look at AI and its effects on access to work. This is because the term “human rights” is perceived by Jamaicans as something negative; a euphemism for an inconspicuous larger agenda that they want nothing to do with, rather than what it really is. Human rights are the basic entitlements of every human being simply by virtue of being human.

The Universal Declaration of Human Rights (UDHR) was created to safeguard these basic entitlements following the atrocities of the Second World War, at the end of which it was unanimously agreed that never again should persons be subjected to such inhumane conditions as brought about by the war. Hence, the birth of the United Nations and its role as the defender and protector of the rights enshrined in the 30 articles of the UDHR.

The key message and overarching point of this discourse is that the need for every Jamaican to know his/her basic rights and the accompanying responsibilities should transcend all other concerns. In order to facilitate the education of Jamaicans about their human rights, thought must be given to the mechanism, methodology and manner in which this can be done.

Perhaps the time is now to revisit the dialogue about the establishment of a National Human Rights Institution (NHRI) in light of the role it would play in carrying out public education in this regard.

You see, the human rights conversation is broader by far than the silos into which it is usually confined – extrajudicial killings and sexual and reproductive health, for example. Instead, in light of the 71st anniversary of the existence of the UDHR on December 10, let us commit to moving expeditiously to create a culture of human rights in Jamaica. Every Jamaican has a right to know his/her human rights and ideally should learn them in school.

Therefore, I close the conversation where it started. As a country, we must equip ourselves to understand the emergent issues of this digital world but we must do so within the context of first knowing our basic human rights while accepting that human rights are dynamic and evolve as the world evolves.

Email feedback to nicolaacousins@gmail.com and columns@gleanerjmm.com

Appendix B – JADS Discrimination Case Reports

Details of Successful Case #348

Client Initials: TacB

Summary of Facts: Case was referred to JFJ for legal assistance to increase maintenance for her child. TacB also requested help to apply for sole custody of her only son. TacB met with JFJ attorney who made an application for sole custody of her child. An interim order was granted to TacB on May 5, 2019. The interim order granted sole custody to TacB and the child's father was given access to the child with the consent of TacB. The child's father is also barred from accessing the child at school until another order is considered.

Nature of Case: Child custody

Key Population: Person Living with HIV

Action Executed: JFJ Attorney attended court on 18 October 2019 and behalf of TacB and the interim Order of May5 2019 was made final on 18 October 2019.

Resolution: TacB now has sole custody of child. Matter was resolved.

Details of Successful Case #363

Client Initials: JST

Summary of Facts: Case was referred to JFJ as JST reported that a community member has been constantly harassing and disclosing her HIV status. This has resulted in the closure of JST business place to close.

Nature of Case: Harassment and involuntary disclosure of HIV status

Key Population: Person Living with

Action Executed: JFJ's Attorney appeared at court on behalf of JST on several occasions and secured a trial date for 5th September 2019. On the 5th September 2019 the community member was charged with using abusive language towards JST.

Resolution: He was found guilty and as penalty is bound over 12 months within which time, the community member is not to interfere with JST in any manner including harassment at place of business and disclosing of JST's HIV status.

Appendix C – Stakeholder Attendance Registers

Attendees at GAM Stakeholders' Meetings

January 23, 2020 – GAM Steering Committee Meeting

NO.	*NAME*	*ORGANISATION*
1.	Dr. Tazhmoye Crawford (Chair)	NFPB
2.	Miss Lovette Byfield	NFPB
3.	Mrs. Manoela Manova	UNAIDS
4.	Dr. Valeska Stempliuk	PAHO/WHO
5.	Mr. Ricky Pascoe	JN+
6.	Mr. Devon Gabourel	NFPB
7.	Ms. Donneth Edmondson	UNICEF
8.	Mr. Marlon Mahon	MLSS
9.	Mr. Marvin Joseph	NFPB
10.	Mr. Conrad Saunders	MLSS/NFPB

February 4, 2020 – Stakeholders' Meeting with HIV Prevention Programme Team

NO.	*NAME*	*ORGANISATION*
1	Tanisha Llewelyn	St. Ann Health Department
2	Patricia Russell	NERHA
3	Chantol Folks	NFPB
4	Tania Brown	SERHA
5	Sheryll Thomas	Rapporteur
6	Yonique Hanson	SRHA
7	Judene Miller	SRHA
8	Angilee Maragh	SRHA
9	Diana Thaxter	SERHA

10	Samantha Watson	SERHA
11	Ms. Sushan Stewart	NFPB
12	Dr. Tazhmoye Crawford (Chair)	NFPB
13	Ms. Andrea Campbell	NFPB
14	Dr. Suzanne Robinson Davis	Consultant

February 6, 2020 - Stakeholders' Meeting with Jamaica Network of Seropositives Team

February 7, 2020 - Stakeholders' Meeting with Enabling Environment & Human Rights Team

NO.	*NAME*	*ORGANISATION*
1	Mr. Devon Gabourel	NFPB
2	Ms. Genice Wright	NFPB
3	Ms. Nicola Cousins	NFPB
4	Mr. Conrad Saunders	MLSS/NFPB
5	Sheryll Thomas	Rapporteur
6	Dr. Suzanne Robinson Davis	Consultant

February 11, 2020 – Stakeholders' Meeting with Civil Society Organizations

NO.	*NAME*	*ORGANISATION*
1	Mr. Devon Gabourel	NFPB
2	Ms. Genice Wright	NFPB
3	Ms. Nicola Cousins	NFPB
4	Mr Kurt Schmick	ASHE
5	Ms. Olive Edwards	JCW+
6	Mr. Jovane Blagrove	Children First

7	Sheryll Thomas	Rapporteur
8	Dr. Suzanne Robinson Davis	Consultant

February 19, 2020 – GAM Steering Committee Meeting

NO.	*NAME*	*ORGANISATION*
1.	Dr. Tazhmoye Crawford (Chair)	NFPB
2.	Miss Lovette Byfield	NFPB
3.	Dr. Valeska Stempliuk	PAHO/WHO
4.	Mr. Devon Gabourel	NFPB
5.	Mr. Marvin Joseph	NFPB
6.	Mr. Conrad Saunders	MLSS/NFPB
7.	Mrs Claudette Grant-McLeish	NFPB
8.	Mr. Meguel Julien	MOHW
9.	Dr. Suzanne Robinson-Davis	Consultant

March 3, 2020 – GAM Steering Committee Meeting

NO.	*NAME*	*ORGANISATION*
1.	Dr. Tazhmoye Crawford (Chair)	NFPB
2.	Mr. Devon Gabourel	NFPB
3.	Mr. Marvin Joseph	NFPB
4.	Mr. Conrad Saunders	MLSS/NFPB
5.	Mrs Claudette Grant-McLeish	NFPB
6.	Dr. Suzanne Robinson-Davis	Consultant
7.	Dr. Tanisha Hickman	MOHW
8.	Mr. Xavier Biggs	JASL