

## **AIDSTAR-Two Project Trip Report – Jamaica 01/09/11**

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5 key words:

MARPS, National AIDS Commission, HIV NGO sector, USAID, causal analysis

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## AIDSTAR-Two Project Trip Report

### **1. Scope of Work:**

Destination and Client(s)/ Partner(s)	Jamaica USAID/PEPFAR Mission Jamaica
Traveler(s) Name, Role	Elden Chamberlain Most at Risk Populations Specialist AIDSTAR-Two
Date of travel on Trip	Jan 9-15 2011
Purpose of trip	Work with consultants to finalise chapters 1-5 of report. Conduct stakeholder meeting with NGO sector project briefings with USAID/PEPFAR
Objectives/Activities/ Deliverables	Finalized Draft chapters 1-5 of report Conduct project briefings with USAID and National AIDS Council Conduct consultation/stakeholder meeting with NGO sector
Background/Context, if appropriate.	AS2 is implementing a project that aims to provide guidance/recommendations to the HSS technical working group on how to best address MARPS issues through HSS interventions, target countries are Vietnam and Jamaica

### **2. Major Trip Accomplishments:** Should include the major programmatic goals realized, relevant metrics, and stories of impact from the trip.

Draft Chapters 1- 5 revised (attached)
Stakeholder meeting with NGO Sector held (ppts attached)
Positive meeting with Director of National AIDS Commission
<p>Trip was very fruitful and much was achieved. Two days of intensive work was spent with the consultant and the Alliance Country Director, during which briefings were held with the NAC and USAID as well as the agenda and presentations for the stakeholder meeting were developed. (attached)</p> <p>Meeting with USAID very positive. Catherine Zilber from the mission is extremely helpful and assisted greatly in setting up meeting with Director of the National AIDS Council. Catherine Zilber is happy with draft report developed and wished to share both the report and the causal analysis framework with her Caribbean colleagues during the regional PEPFAR meeting. She was keen for us to make sure we addressed legislative/policy issues as well as consider the definition MARPS to increase the scope of sex workers and their clients.</p> <p>Meeting with Kevin Harvey, Director of National AIDS Commission was useful to ensure their support of the project. He was also pleased with the draft report to date and wanted to use it as part of the briefing for the mid term evaluation of the national strategy that was taking place later this year. He requested that on our return visit we set up a meeting with his whole team to discuss the findings of the report. He provided background information about a whole of government approach to HIV he was developing and hoped that our report would offer support to this type of approach.</p> <p>The stakeholder meeting was attended by 22 people from the HIV NGO sector, representing the major implementers in the country. The meeting started with an introduction to the project/ HSS/causal analysis and then focused on verifying the information gathered in the first 5 chapters of the report. In the afternoon the focused shifted to discussing key issues for improving MARPs services and better understanding the response to date and the information/data needed to make decisions about program priorities. The meeting was useful in garnering the NGO sector support for the project and verifying the information and conclusions we had already come to- namely that in Jamaica there has been very little work done on truly understanding what drives the epidemic amongst MARPs and that program decisions are based on what is perceived to be best practice from other regions with no real impact / effectiveness data to support it. As a follow on we undertook to have a repeat meeting when the final report and recommendations is developed.</p>

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**3. Next steps:** Key actions to continue and/or complete work from trip.

Description of task	Responsible staff	Due date
Debrief with USAID Washington	E Chamberlain	19 January
Follow up teleconference with consultant	E Chamberlain	26 January
Final chapters 1-5 completed	Consultant	28 January

**4. Contacts:** List key individuals contacted during your trip, including the contacts' organization, all contact information, and brief notes on interactions with the person.

Name	Contact info	Home organization	Notes
Kevin Harvey		Director Jamaica National AIDS Commission	
Denise Chevannes	dchevannes@alliancecarib.org.tt	Country Director Carribean AIDS Alliance	
Renee Johnson	moniquejohnson@gmail.com	Consultant for Project	
Catherine Zilber	czilber@usaid.gov	HIV AIDS Program Officer USAID Jamaica	

**5. Description of Relevant Documents / Addendums:** Give the document's file name, a brief description of the relevant document's value to other staff, as well as the document's location in eRooms or the MSH network. Examples could include finalized products and/or formal presentations, TraiNet Participant List, Participant Contact sheet, and Meeting/Workshop Participant Evaluation form are examples of relevant documents.

File name	Description of file	Location of file
Draft Report		attached
Introductory ppt for meeting		attached
Ppt of data for meeting		attached

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## Health Systems Strengthening for Most at Risk Populations

Jamaica

January 12, 2011

Welcome & Introduction Elden Chamberlain- AIDSTAR II	10:00 am
Background of Project Elden Chamberlain- AIDSTAR II	10:15 am
Introduction to the Health System Strengthening Elden Chamberlain- AIDSTAR II	10:45 am
Validation of Epidemiology and Characteristics Most at Risk (MARPS) Draft Document Renée Johnson- Consultant	11:30 am
<b>Lunch</b>	12:00pm
Mapping Exercise of Organizations and Activities Renée Johnson	1:00 pm
Gaps and Challenges in Health Systems for Prevention Intervention for MARPS (Group Work) Denise Chevannes- CHAA	1:45 pm
Next Steps Elden Chamberlain- AIDSTAR II	2:30 pm

## Chapter 1 - Background

Jamaica is the largest English speaking Caribbean island, with a population of 2,692,400 (Planning Institute of Jamaica 2009). By World Bank standards, Jamaica is considered an upper middle income country (UMI). In 2006 it spent approximately 5% of its gross domestic product on healthcare. One of the biggest health and developmental issues in the Caribbean is HIV and AIDS, where there is a prevalence rate of approximately 1%; however Jamaica has a slightly higher adult prevalence rate of 1.7%. HIV stands to affect not only the health of the Jamaican people but also the development due to loss of productivity and time because of the morbidity of the illness. In a declining global economy Jamaica has to identify cost effective means of mitigating the impact of HIV and AIDS.

When compared with most countries in Latin America and the Caribbean (LAC), a greater portion of Jamaica's total health expenditure (THE) comes from the local budget and not international donors. Jamaica's THE in 2006 was 5.1% of the Gross Domestic Product (GDP) and of this only 1.3% was received from International Development Partners (IDP) (Bethseda 2010). Compared to other countries in LAC and other Upper Middle Income (UMI) countries this percentage of the GDP on THE is low, as those countries spent 6.6% and 6.3% respectively in 2006. A low percentage of GDP spent on health services indicates that there are inadequate health services and technology and thus a less effective health system with low coverage. (Bethseda 2010)

The Ministry of Health's National Strategic Plan (MOHNSP) for 2006-2010 identifies that health and development are 'inextricably linked' (Ministry of Health 2006). The plan also assumes that the health determinants are not just biological and genetic but are also political, social and economical. Therefore, the vision of this plan is '*Better health, wellbeing and quality of life for all*'. The Mission and Policy Outcome are given in the table below:

Figure 1 Mission and Outcomes of the Ministry of Health's 2006-2010 Strategic Plan

### **Mission**

Ensure access to a sustainable, responsive and effective health system that is stakeholder focused and facilitates the health, productivity and well being of Jamaicans.

### **5.3 Policy Outcome**

The Ministry of Health shall in keeping with the development goals and philosophies of the Government of Jamaica as well as regional and international guidelines, formulate, monitor and evaluate policies, plans and programmes that:

- Promote well being and health in the society so that the population enjoys sustained, optimum levels of health.
- Ensure health systems that are well managed and sensitive to the health needs of the population.
- Continue further improvement and modernization of the health system to promote equitable access to appropriate, affordable, effective services.

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The MOHNSP's vision and mission are akin to the Vision 2030 plan set out by the Planning Institute of Jamaica (PIOJ) which has a goal of a healthy and stable population. (Planning Institute of Jamaica 2010)

*Our vision is for a country with a health care system that is affordable, provides services in locations that everyone can reach, has facilities that are well-equipped, and is fully staffed with highly trained personnel. We will increase our ability to fight diseases that we can get from others (infectious diseases) as well as those that we develop because of how we live (lifestyle diseases). Our life expectancy (the age to which we are expected to live) will increase from 72 years to 76 years. The size of the population will be stable, increasing slowly over time in a balanced way to support our development.*

The MOHNSP for 2006-2010 has five objective areas. These include: population health, individual health, quality management, disaster management and leadership and management. As can be seen from table below HIV/AIDS is related only to the outcomes of the individual health objective.

**Table 1 Theme Objectives of National Health Plan of 2006-2010 highlighting HIV**

Themes	Objective	Focus on HIV
Population Health	To promote wellness and protect the health of the Jamaican population thereby reducing the incidence and severity of preventable illness, injury and disability	No
Individual Health	To improve individuals' health outcome by ensuring access to effective, affordable and equitable health care services	Yes
Quality Management	To improve the quality of health care provided to the nation	No
Disaster Management	To improve the Ministry of Health's ability to prepare for and respond to health threats from manmade/natural disasters	No
Leadership and Management	To strengthen the leadership and management of the Ministry of Health to achieve organizational objectives	No

Further to this, there is a National HIV Strategic Plan for 2007-2012 (NSP) and a complementary National Monitoring and Evaluation Plan (NEMP). The National HIV Strategic Plan has four main priority areas: prevention, treatment and care, enabling environment and empowerment, and governance. The table below indicates the priority areas and corresponding strategic objectives which focus on MARPs. Three of the four priority areas have strategic objectives focused on MARPs, however only one of the areas indicate that there are any challenges which affect MARPs. The priority area in which challenges affect MARPs is Enabling Environment. Under this priority area it was noted that stigma and discrimination towards MSMs does and can affect the attainment of the goals of this priority. (National HIV/STI Programme 2007)

The stigma and discrimination which afflicts the MSM and SW communities is related to laws of Jamaica which deem the sex between two males to be illegal as well as sex work. These are found as sections in the Offences Against the Persons Act. However it should be noted that there is a National HIV Policy (as well as several sector policies) which have been endorsed by cabinet regarding the management of HIV and AIDS. A Green Paper has been tabled in the House of Representatives with respect to HIV and AIDS

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Workplace Policy. This policy speaks to mitigating HIV stigma and discrimination in the workplace. Although these policies are not MARPs specific it indicates the support of the government and politicians in mitigating the HIV epidemic and the issues which impact this process. Previous legislation also allows for the NHP, which is currently a project under the Health Protection Unit at the Ministry of Health, to implement HIV programmes and activities. Under the Public Health Act the Minister of Health has the right to order not only an investigation to any disease of public health concern but also to implement any measure necessary to arrest the spread of the public health disease. If necessary, boards and committees may be set up to assist in the mitigation and prevention of the public health illness. To this end the NHP is able to direct activities to assist in the mitigation of HIV in Jamaica.

The majority of the National HIV Strategic Plan is funded by IDPs, such as the World Bank (WB) and the Global Fund against AIDS Tuberculosis and Malaria (GFATM). Although there is international aid with respect to HIV funding there is still a 67.3 % shortfall in the funding for this plan indicating the inability to effectively complete all activities due to insufficient funds. Currently the NSP is expected to cost USD 201.2 million; however only USD 65.7 million is available.(Planning Institute of Jamaica 2009). Further to this HIV only accounts for JMD 1.2 billion of the MOH's JMD 31 billion budget; indicating that it is not a big part of the health budget and that the sector possibly has other priority areas.

Agreements with the IDPs require that local governments fund 80% of the administrative cost, however, in the case of Jamaica this percentage may actually be higher, as the value of time and resources in the public health system which are used to render HIV services such as; laboratory testing and treatment of opportunistic infections among others have never been quantified. Between the calendar years of 2007-2009, the majority of the total HIV budget was spent on Treatment and Care and Prevention. In 2009 JMD 390.69 million (36% of total HIV budget) was budgeted towards Treatment and care with JMD555.54 million actually being spent. This saw an actual 42% more in spending that was expected. Similarly in 2009 Prevention was budgeted at 29% of the HIV budget at JMD 314.07 million; however JMD 325.15 million, a 3% more than was budgeted, was actually spent. To this end the actual HIV budget for the calendar year 2009 exceeded its estimated budget by 12 %. Of note is that in the years 2007 and 2008 all components in the HIV budget was under spent; in 2009 all other components except for treatment and care, prevention and capacity building there was under spending. Over budgeting could be indicative that there is no real knowledge of things needed to effectively deliver HIV services in Jamaica. Under budgeting in the year 2009 could be a result in the world economic situation where prices increased dramatically for food, services and commodities.

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**Table 2 Priority Areas of National HIV Strategic Plan and its associated challenges & strategic objectives which focus on MARPS**

Priority Areas	Challenges that affect MARPs	Strategic Objectives that focus on MARPs
Prevention		<ul style="list-style-type: none"> <li>• Research based prevention efforts</li> <li>• Drug Abuse</li> <li>• Vulnerable Populations</li> <li>• Gender and Social Vulnerability</li> </ul>
Treatment and Care	-	<ul style="list-style-type: none"> <li>• HIV Testing</li> </ul>
Enabling Environment	<ul style="list-style-type: none"> <li>• MSM Stigma and Discrimination</li> </ul>	<ul style="list-style-type: none"> <li>• Identification and support for champions for change for other law reform and advocacy, which protect the rights of all Jamaicans including the vulnerable and the marginalized.</li> </ul>
Empowerment and Governance	-	-

Evidence over the years has indicated that the burden of HIV transmissions and prevalence lies in what are considered the most vulnerable and most at risk populations (MARPs). To this end both the Caribbean Strategic Framework 2008-2012 (CRSF) and the NSP have strategic objectives under their priority areas which focus on MARPs. UNAIDS considers MARPs to be: sex workers (SW), clients of sex workers, intravenous drug users (IDU) and men who have sex with men (MSM). However in Jamaica MARPs are considered to be MSM and SW with prevalence rates of 31.8% and 4.9% respectively. IDUs are not considered MARPs in Jamaica as the rate of infection for this group is 0.8% even less than the general population at 1.7%. However, homeless crack cocaine users are considered to be a sub population most at risk at approximately 6.3% of all HIV/AIDS cases reported.

**Table 3 MARP Groups as classified by UNAIDS and the NHP**

UNAIDS MARPs Sub-groups	NHP MARPs Sub-groups
MSM	MSM
SW	SW
Clients of Sex Workers	Crack Cocaine Users
IDU	Inmates
	STI Clinic attendees
	Out of School Youth

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**Table 4 MARPS Size and Prevalence Estimate(Harvey 2010)**

<b>Population</b>	<b>Estimated Number</b>	<b>HIV Prevalence</b>
Crack cocaine users	4,000	5%
Sex workers	7,000 – 18,000	5%
MSM	9,000 – 27,000	32%
Prison inmates	5,000	3.5%
STI clinic attendees	45,000	3.4%

For this study the focus will be on MSM and SW. At present there is a dearth of information relating to homeless crack cocaine users as well as to clients of sex workers. Crack cocaine increases one's vulnerability to HIV/AIDS as it decreases one's cognitive skills and hence condom negotiating becomes difficult. To date only 138 reported cases of the 14,354 HIV/AIDS cases have been IDUs. Culturally, Jamaicans do not use needles, thus the extremely low HIV prevalence among such a population.

As stated previously an NSP guides and directs the National HIV Programme (NHP) and it has four priority areas. In its overall aim to stem and mitigate the impact of HIV transmissions in Jamaica, further strategies have been designed under the prevention priority. A behaviour change communication strategy with emphasis on MSMs and SW has been developed by the Prevention unit at the NHP. The strategy also has sub strategies such as Positive Prevention and Out of School Youth (OSY) for other vulnerable sub groups.

The objectives of the behaviour change strategy for MSMs are not clearly stated. However for SW the objectives are to:

1. Promote condom use
2. Promote health seeking behaviour
3. Promote less drug use

The President's Emergency Fund for AIDS Relief (PEPFAR) started a new five year cycle in 2009 partnering with twelve Caribbean islands, one of which is Jamaica. The goals and objectives of the PEPFAR II Framework are closely linked to the five priority areas of the CRSF. Under its partnership with Jamaica, which involves six United States Government (USG) agencies (HRSA, Peace Corps, CDC, State Department, Department of Defence and USAID) the PEPFAR II general objective states that, "The primary, shared goal of the six agencies working under PEPFAR is to support the Government of Jamaica's efforts to reduce the transmission of HIV over the next five years, with a focus on most-at-risk populations (MARP) and other vulnerable populations."

Undoubtedly all strategic plans and partnerships are focused on the reduction of HIV transmission in the MARPs, as they have been recognized locally and globally to carry the burden of the illness.

High rates of HIV prevalence among MSM and SW in Jamaica, just like other countries globally, are directly linked to its legal frameworks which deem same sex acts between men and sex work to be illegal activities. As a consequence these groups are driven underground and become much harder to

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reach. The inverse is seen when there is no legislation against these acts as in the Bahamas and the Dominican Republic where HIV prevalence rates are lower.

Jamaica's vision 2030, its MOHNSP and the NSP have all identified health and in turn HIV as areas to be addressed for Jamaica to reach its full potential and be classified as a developed nation. However with only approximately 5% of its GDP being spent on health this target may be difficult to achieve. This is even more difficult as at the end of 2008 there was almost a 70% gap in funding the NSP. To this end it is imperative that health expenditure and more so HIV expenditure are effectively spent to have the greatest impact, thus contributing to the broader development of Jamaica.

## **CHAPTER 2 –Epidemiology of Jamaica**

The adult prevalence rate for HIV/AIDS in Jamaica is 1.7%. There has been a slight increase from 1.5% over the past decade. This increase is due in part to the fact that more people are living longer with the illness due to greater access to anti-retrovirals (ARVs). Although the epidemic is generalized, it is also concentrated among some sub-populations. These include MSM at 31.8% prevalence and sex workers at 5% prevalence rate. Other vulnerable populations include crack cocaine users at 5% and incarcerated persons at 3.3 %.

The number of new HIV cases has increased over the past 10 years from 1,436 in 1999 to 1,738 in 2009. This increase is due to several factors: new HIV infections, increased surveillance, increased access to HIV testing, increased awareness by health care workers, and increased awareness by the general population.

80% of HIV infections are believed to be transmitted through multiple sex partners. About 20% of persons who have been infected with HIV/AIDS since the recording of HIV data in 1982 until 2009 have a history of sex with sex workers. Although this information has been recorded, not much is known about this group of persons and no targeted interventions have been developed for them. Approximately 90% of all HIV infections are attributed to heterosexual contact. However, there are approximately 43% of men who were diagnosed with HIV, whose sexual orientation was unknown. Of those whose sexual orientation was known, 4% identified as bi-sexual and another 3.4% as homosexual. Twenty-four out of every one thousand STI clinic attendees was HIV positive in 2009. Of particular interest is that 25 % of all HIV transmissions are undetermined while 69% of them are attributed to sexual contact as seen in Figure 3. HIV risk factors have remained constant over the last ten years indicating that, although some mitigation with transmission of the virus has taken place, the behaviours of the society have remained the same and in order to stunt the epidemic all programmes need to address these constant risk issues.

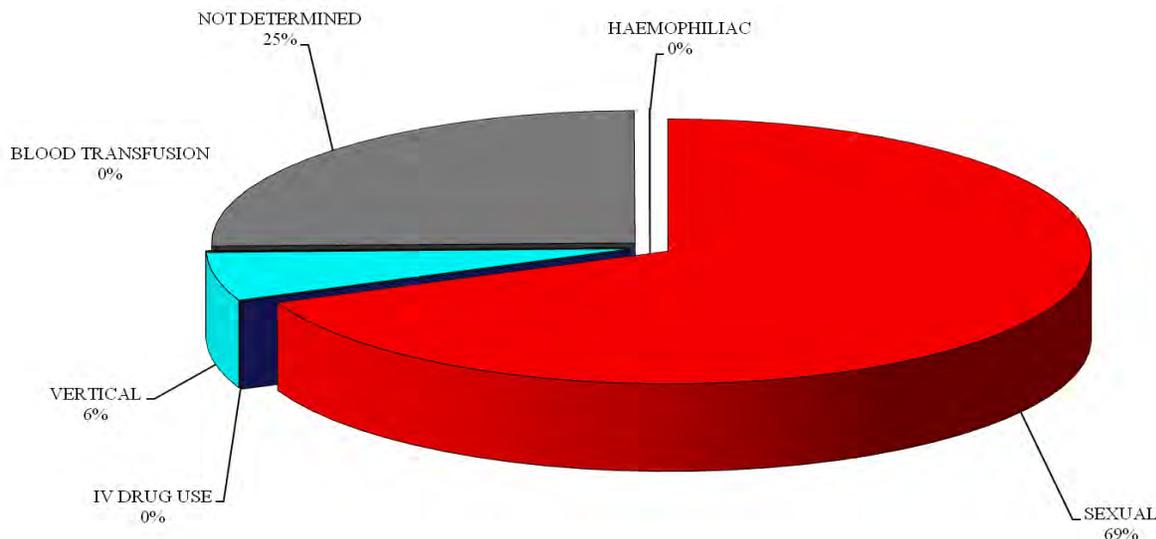
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**Table 5 Reported risk behaviours among adults with HIV (1982 – Dec 2009 cumulative) N= 18,130<sup>1</sup>**

Risk	No of persons (%)
Sex with sex workers	3,581 (19.7)
Crack, cocaine use	1,138 (6.3)
STI History	8,137 (44.9)
IV Drug user	139 (0.8)
Multiple Sexual Partners	>80%
No high risk behaviour	5,135 (28.3 )

The most urbanized areas account for the highest prevalence of HIV, with 66% of HIV/AIDS cases being found in these areas. The areas include Kingston & St. Andrew, St. Ann, St. Catherine and St. James. St. James has the highest cumulative prevalence rate of 1,854 per 100,000 persons. This is followed by Kingston & St. Andrew and St. Ann with 1,432 and 1,038 per 100,000 persons respectively. The economies of St. James and St. Ann are driven by tourism, therefore making the tourism sector and area vulnerable to the transmission and impact of HIV/AIDS.

**Figure 2 Jamaica HIV Transmission by Category 1982-2009 (Harvey 2010)**

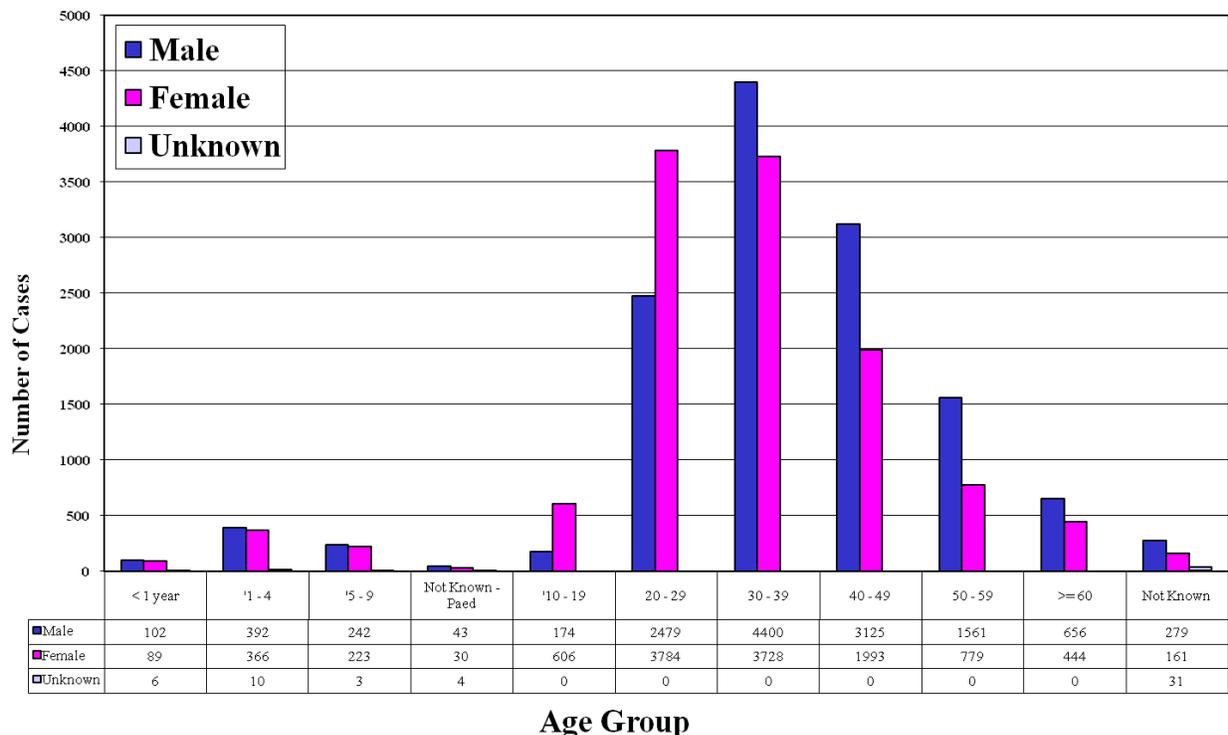


<sup>1</sup> Taken from Ministry of Health, National HIV/STI Programme, Jamaica AIDS Report 2009, Kingston Jamaica,

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Age also seems to factor highly in HIV transmission and AIDS prevalence. 79% of the persons with AIDS are in the age group 20-49. This is a 10% increase from 2008 (National HIV/STI Programme 2010). However, it is similar to the cumulative rate for 1982-2009 which is 74%. This slight increase can be attributed to new infections as well as to antiretroviral treatment, thus persons are living longer with the virus. Further to this the ratio of male to female HIV/AIDS prevalence cumulatively from 1982-2009 is 1.35:1; however the ratio for male to female for 2009 is even closer at 1.2:1. (National HIV/STI Programme 2010)

**Figure 3 Jamaica, HIV by Age and Gender (National HIV/STI Programme 2010)**



The KAPB 2008 study also highlighted that 27% of persons had not used condoms in their last ten (10) sex acts. This data is important as the majority of persons who are HIV positive do not know their status, thus increasing the chance of transmitting HIV. Non condom use is also related to age and multiple partners. Most persons with multiple partners in the age group 15-24 were more likely to use condoms. This is also related to the fact that many of these persons were not in committed relationships. Lack of condom use is related to trust within relationships as well as cultural beliefs and norms. Males stated discomfort or unnatural feeling with the use of condoms. Interestingly there has been a slight decrease in persons reporting sex with a sex worker between the years 2004 and 2008; however condom use by clients of sex workers in the age groups 15-24 and 25-49 has also decreased. In 2004 the percentage condom use at the last interaction with a SW worker was 75.5 % and 80% respectively in the 15-24 and 25-49 age cohorts respectively as compared to 69.2% and 60% respectively in 2008. (Hope Enterprises 2008)

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Transactional sex was reported by at least one third of the respondents interviewed in the 2008 KAPB survey. Transactional sex denotes sex in exchange for cash or goods. This activity inherently reduces condom negotiation power and strength, as the person receiving the cash or goods is willing to do anything requested of them in order to attain financial and material gain. The percentage of men who engaged in transactional sex was two times more than that of the women. Transactional sex is defined as both giving and/or receiving gifts. Further to this persons reporting transactional sex engaged in sexual activity more often than those who were not engaging in transactional sex. Coercive sex which is sex by force also affects the use of condoms. Over 20% of the SW who were apart of the 2008 sex worker interview were raped. Approximately 18.8 % of the HIV positive MSM who took part in the 2007 survey were also victims of rape. (National HIV/STI Programme 2008)

**Figure 4 Other Risk Characteristics which affect HIV Transmission**



As stated above the reported prevalence of HIV/AIDS has increased slightly which is indicative of several factors. Two of these include increased access to voluntary counselling and testing (VCT) by the population, which increases the known number of people living with HIV, as well as a reduction in mortality, which increases the actual number of those living with HIV. In the case of access to VCT, there was an increase in the percentage of persons indicating that they have taken an HIV test in the last twelve months and received their results. A greater increase was seen by women as well as by the age group 24-49. There was a 14.7 % increase use of VCT by women from the year 2004 to the year 2008, while with men there was a 11.4% increase (Hope Enterprises 2008). With respect to mortality, a total of 7,772 have died from AIDS since 1982, which is approximately 50% of the total who have reported AIDS. However, the rate of mortality is on the decline. In 2004 a total of 665 persons succumbed to AIDS related illnesses however in 2009 only 378 persons died due to AIDS, indicating a 43% decline in the AIDS related illnesses. This decline in AIDS related illnesses can be attributed to increased access to anti-retroviral treatment, increase capabilities in laboratory services such as CD 4 counts and viral load, as well as increased earlier diagnosis and opportunistic treatment because of scaling up of the national VCT programmes. (National HIV/STI Programme 2010)

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Figure 5 Behaviour Changes noted by KAPB 2008 study

- Increase by 14.7% and 11.4% females and males respectively in knowledge of HIV status
- Up to 20% decrease in condom use with SW
- Percentage decrease in persons reporting sex with a SW
- 27 % persons did not use a condom in their last sex act

### **Chapter 3- Strategic Targets for Jamaica**

The NEMP has set targets to be achieved by 2012. These targets will be the result of the implementation of activities related to the four priority areas of the NSP. The targets for the various sub-groups are based upon both IDP indicators, global indicators such as UNGASS indicators, as well as local indicators set by the NHP. The indicators are categorized as impact, outcome and output.

The baseline prevalence rates and numbers of some targets for the vulnerable populations such as the MSM community are not known. This makes it difficult to determine how severe the problem is currently, as well as if any real impact will be made by the programmes implemented under the NSP. An UNGASS indicator to be determined is the *percentage of men reporting using a condom the last time they had anal sex with a male partner*: the baseline value for this indicator has yet to be decided with the baseline year being 2003. However, there is a target of an increase of 10% and 20% over the baseline for 2010 and 2012 respectively.

Targets are not specific to geographical regions; however they are specific to sub-populations and age groups. The baseline years vary depending on the target and the source of the data to inform target indicators. As a result the timeframe for attaining targets may differ from two to three years and/or may have more than one target year during the strategic period. If the previous UNGASS indicator is to be used as an example an overall 20% increase from the baseline number is expected at the end of the strategic period, however an initial 10% increase is expected within the first 2 years.

There are also general population targets, which would inevitably incorporate the vulnerable and most at risk populations. By 2011 the NHP would like at least 80% of males and 75% of females to report using a condom the last time they had sex with a non-regular partner. This target includes the entire population and can be disaggregated by vulnerable groups, sex and age.

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**Table 6 Selected targets and indicators for the HIV strategic period 2007-2012 (Jamaica National HIV/STI Programme Monitoring and Evaluation System 2007-2012, 2007)**

Indicator Source	Indicator	Frequency	Base Line		Target		Priority Area
			Value	Year	Value	Year	
UNGASS	Percentage of men and women aged 15-24 that are HIV infected	Annually	1.2% 1.5%	2002 2005	≤1.5%	2009 2011	Prevention
UNGASS	Percentage of SW who are HIV infected	2005 and every 2 years	9%	2005	7% <7%	2010 2012	Prevention
UNGASS	Percentage of MSM who are infected	2006 and every 2 years	25%-30%	2007 estimate	<25%	2011	Prevention
USAID	Number of individuals reached through prevention activities, disaggregated by vulnerable groups. (eg. Youth, MSM, SW, prisoners)	monthly	SW -3480 MSM- 4800 STI Clinic Attendee- 40,000 Inmates- TBD		SW-8500 MSM- 6600 STI Clinic- 225,000 Inmates - 3000 (all cumulative)	2012	Prevention
UNGASS	Percentage of SW reporting using condom at last sex act with client	2005 & every 2-3 yrs	75% 92%	2003 2005	>90%	2011	Prevention
UNGASS	Percentage of men reporting using condom the last time they had anal sex with a male partner	2006 & every 2-3 year	TBD	2003	10% increase  20% over baseline	2010  2012	Prevention
UNGASS	Percentage of people by sex, age and at risk group who received HIV testing in the last 12 months and who know the results	Every 2 years	SW-43% MSM- TBD	2005	SW 50%	2012	Treatment and Care

## Chapter 4

### Characteristics of MARPs

In Jamaica MARPs are seen as SW, MSM, crack cocaine users and prison inmates. IDU are not considered MARPs in Jamaica, accounting for less than 1% of all HIV/AIDS cases ever reported. In this report we will be focusing on the characteristics of two of the most at risk populations. These are MSMs, with 31.8% prevalence and SW with 5% prevalence. Although the prevalence among crack cocaine users, especially those who are homeless is approximately 5% (National HIV/STI Programme 2010), very little is

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documented about the population's characteristics and their HIV status; however many sex workers have reported drug use, additionally many MSM are homeless and are sex workers. An analysis can possibly be drawn that some of the HIV positive drug users may be SW and MSM or both.

### **Men who have sex with men**

The population of MSM is estimated to be between 9,000 and 27,000 (Harvey 2010). As stated previously from a 2007 survey of 201 MSM, the HIV prevalence was found to be 31.8%. Condom use among this population was fairly low. Less than 30% reported using condoms with regular partners. This group, like the general population, has a fairly high number of multiple sex partners. Over a quarter of the MSM had two or more male partners in the 4 weeks prior to the survey. Another 33% reported having sex with more than one female in the last 12 months (National HIV/STI Programme 2008). This statistic is also indicative of the intersecting of MSM and the general heterosexual population.

Of the MSM who were HIV positive almost 19 % of them had been raped and 21.9% had been physically abused. These statistics possibly support the MSM behaviours espoused in a 2010 qualitative research study by Dr. Moji Anderson which identified that many MSM take on the submissive roles of females. Thus they become vulnerable and have less control in relationships and are comfortable with being abused by the more dominant partner. Physical abuse and coercive sex also fuel the issue of lack of condom use or inconsistent condom use among this community. Another symptom of taking on the female role is that the '*feminine*' partner wants to feel the '*baby sperms*' inside of them supporting the issue of lack of condom use among the community. (Anderson 2010)

MSMs can also be categorized by their biological characteristics. That is to say an MSM who is a "*bottom*" or receiver is at greater risk of being HIV positive. The study estimated that 73.4 % of the men who were HIV positive were receivers as compared to 64.1% who were givers or "*tops*". Verses, which are men who both give and receive, had 57.8% prevalence. These results speak to the fact that receivers are more at risk from a biological and physiological standpoint. Another biological risk for MSM is a history of STI. 8.5% of the men in the 2007 study had chlamydia and 5.5 % had syphilis. This is an indication that there is a link between HIV and a history of STIs. It should be noted that approximately 39% of the participants who reported an STI or genital or anal discharge did not seek treatment for it, which also increases one's risk for HIV. The correlation between HIV and a history of STI is also validated by information collected from HIV/STI clinics which indicate that in 2009, that twenty-four (24) out of every thousand persons with an STI was infected with HIV.

Socio-economic issues also impact the behaviours and HIV risk of MSMs. 23.4 % of the MSMs in this study who were diagnosed with HIV were homeless. Further to this, MSM can be categorized by different characteristic based on their socio-economic standards. These include the phenomenon of the group of men called the "*sweepstaker*". (Anderson 2010) The '*sweepstaker*' is normally a transgender who has come upon wealth due to lottery scams. As a result of their wealth they are able to determine condom use within their sexual interactions, especially with homeless and street-based MSMs. An interesting fact that has been brought out by professionals who work with MSMs is that some MSMs/transgender choose to be homeless so that they can be with their friends on the streets.

## Health System Strengthening for HIV and AIDS response targeting MARPs Jamaica

Figure 6 Categories of MSM



Figure 7 Risk Behaviours and Characteristics of MSM



The 2009 NHP Annual report states that it is easier to access MSM of lower classes than the middle to upper classes who prefer to be anonymous and who may not perceive themselves to have risks. This notion is supported by the 2010 study by Dr. Anderson which intimated that many middle to upper class men and professional men are either down low homosexual or go as far not to have relationships and interactions in Jamaica but internationally.

An interesting culture of the MSM community is the parties they attend. Some argue that these parties are where the clandestine interactions between the upper/middle class and the lower class MSM take place. In speaking to some experts in the field, it is believed that the sweepstakers are the missing link between the upper class/middle class men and the lower class men. These men have the financial means to fit into the middle to upper class circles; however they maintain a base and relationships with lower class men. These parties are places to meet new sex partners and engage in sexual activities. Although condoms may be available the efficacy of condom use is affected because of impaired judgement due to the consumption of alcohol. Additionally, these parties have inter-socioeconomic class mixing; to this end the males of the lower socio-economic class tend not to have as much power in the use of condoms in this situation. There are also reports of sexual interaction with more than one partner at these parties. These parties which many MSM attend should be targeted as places for intervention activities.

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The internet plays a significant role in the lives of MSMs. They meet new and potential partners on websites and blogs. (Anderson 2010) It is not certain what percentage of MSM in Jamaica use these websites and what role it has in HIV transmission, however it should be considered a place for prevention activities.

A part of the MSM culture in Jamaica is the phenomenon of “gay for pay” men. (Anderson 2010) These men only sleep with men for financial gain and are not gay but heterosexual. This is another MSM group which engages in sexual activity with women. Condom use with male partners by MSMs who have sex with females is higher than their male counterparts who don’t engage in sex with females. It should be noted though that this does not translate into condom use with the females.

Confounding the issues of MSM is that many MSM and transgender persons engage in sex work. It was also noted that some of the transgendered men have sex with heterosexual men; from anecdotal comments sometimes without the knowledge of the heterosexual male.

It should also be noted that stigma and discrimination affect the behaviour of MSM. This is why some MSM are down low and choose to have clandestine relationships with other males including male sex workers. This is supported by the 2008 MSM survey where more than 50% of the recipients had been verbally abused at one time or another because of their sexuality. Further to this more than 20% of the MSM who were HIV positive had spent a night in jail as well as been physically abused. These statistics indicates that due to stigma and discrimination caused by laws although not directly linked to HIV transmission it affects the behaviour of MSMs. These behaviours are such that they increase the social vulnerabilities of the group. Among the MSM population, just like the general population, there are intergenerational relationships. In the case of MSM, school boys are known to have sex with older men for financial support and/or to explore their sexuality in a ‘safe place’. This, however, leaves the naive school boy at risk as they have no condom negotiating power in these relationships.

**Table 7 Percentage of HIV positive males displaying certain risk characteristics from MSM survey 2008 (National HIV/STI Programme 2008)**

Characteristic/Behaviour	Percentage of HIV positive MSM
Homeless	23.4
Biological “bottom”	73.4
Coercive Sex	18.8
Physical Abuse	21.9
Spent night in jail	23.4

Various types of MSM and their characteristics can be identified; however there is no information as it relates to percentages of the population who belong to each category of MSM. Additionally there is not much information on the HIV prevalence in each group of MSM and there is no hard data on how the interaction takes place between the varying groups. However, it is safe to say that MSM have multiple partners and have low condom usage and this pattern of behaviour is similar to the general population. An added risk to an MSM is the type of anal sex they partake in, i.e. if they are a receiver they are more at risk. It is also safe to say that violence, whether within or out of sexual relationships, affects the HIV

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status of an MSM, as well as their socioeconomic standards. Parties and gay websites should be evaluated as places to conduct HIV prevention interventions.

### **Sex Workers**

It is estimated that there are 7,000-18,000 sex workers in Jamaica (Harvey 2010). The HIV prevalence within this group is approximately 5%. Sex work in this context is defined by persons who receive cash, in kind or food in exchange for sex. Further to this sex workers can be put in categories of hidden or overt. Overt includes SW who work on the streets, while hidden includes those who work in bars, massage parlours and exotic clubs. (Weir 2009)

Once again a high percentage of the sex workers were from urban areas, that is to say Kingston & St. Andrew, St. Ann and St. James. As with the general population, tourism areas are vulnerable to the impact of HIV and AIDS due to the risk population. The SW population is very mobile. From the survey a great number of sex workers worked in more than two parishes in the last six months. The SWs who are non street workers tend to be more mobile than street workers. In the 2008 study, the percentage of sex workers who were interviewed in the tourism parishes of St. Ann, St. James, Hanover and Westmoreland was greater than the percentage of the total SW population in those areas in 2001. This indicates a trend for sex workers to move toward tourism areas where they are able to work for higher rates. There was a decline in the percentage of sex workers in Kingston. (Weir 2009)

As with MSM, coercive sex is a risk behaviour of sex workers. 21.4% of SWs have been raped while the same percentage has slept outdoors at one time or another in the age group twenty-five years or less. However, it is unclear how many of these are HIV positive. Many of the sex workers have used some form of drugs within the last six months. This includes ecstasy, alcohol, crack cocaine and marijuana. More than 70% report using marijuana in the last six months and about 50% report consuming alcohol on a daily basis. The use of drugs impairs judgement, thus increasing the risk of HIV as condom negotiating skills are compromised.

**Figure 8 Risk Characteristics of Sex Workers**

- Multiple sex partners
- Inconsistent condom use with main sex partners
- Drug use
- History of STIs
- Working in the Tourism Belt
- Coercive Sex
- Slept outdoors
- Age
- Mobility
- Low education
- Low socio-economic class

**Figure 9 Places where sex workers work**

- Streets
- Bars
- Massage parlours
- Exotic dance clubs

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Older sex workers seem to be more vulnerable to HIV and other STIs than the younger ones. 3.7% of the out of the 5% of sex workers who had HIV were in the over 25 age group while over 53% of the persons presenting with an STI were in the over 25 age group. These statistics indicate that older sex workers are more at risk to HIV and other STIs. It has also been observed that those who are HIV positive tend to have less earning power and lower education and tended to be street based. (National HIV Programme 2009)

The sex worker survey also revealed that condom use with regular partners was low among sex workers in both the below 25 age group and the over 25 age group. In the under twenty-five age group the percentage condom use was 30.8%. 27.7 % of the over 25 age group sex workers used a condom with their regular partners. However, there was virtually 100% condom use with new clients. This percentage decreased to about 90% with younger sex workers who were more likely not to use a condom with regular clients and main partners. This behaviour puts the also puts the younger SW at risk, albeit the risk may be a little less than that of older sex workers considering other socio-economic factors such as education and not being street based.

The issue of multiple sex partners is once again highlighted among this group. Not only does over 70% of the SW have main partners, but at least 53% of these main partners have other partners. This is exacerbated by the fact that there is less than 40% condom use with main partners. (Weir 2009)

48.5% of the SWs interviewed were male sex workers. Approximately 25% of all SW twenty-five and under had both male and female sex clients. (Weir 2009) This indicates how the virus is transmitted in the general population.

It may be difficult to map the interaction of SWs with each other and the general population; however we do know that older SWs are more vulnerable than younger sex workers to HIV because of their education status, their higher rate of STIs and the fact that they are street based. Being street based means that they are easier to target for HIV interventions, as most of the street based SWs are less mobile than the ones who operate out of bars and clubs. This does not mean that younger sex workers are not vulnerable as they have a higher percentage of inconsistent condom use and as the KAPB 2008 study has implied, although fewer men are engaging with SW, there is a decline in the use of condoms.

### **Chapter 5- Evidence Based Prevention Interventions**

In Jamaica HIV transmission for both SWs and MSMs is directly linked to multiple sex partners and inconsistent or no condom use. However socio-economic and psychosocial issues, such as poverty, lack of education and drug use also fuel the epidemic. A successful impactful prevention will have to be holistic and address not only direct contributors but also indirect ones.

Holistic prevention intervention programmes have been implemented in several parts of the world including India (Maria Laga 2010) and Eastern Europe and Central Asia. (UNAIDS 2006)

This encompassing or empowerment approach has several facets. It includes various methods to assist the sex worker and the MSM. In the case of the SW the programme has components such as outreach,

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peer education, and increased access to SW friendly medically services. It also includes the strengthening of community organizations to assist in the empowerment and the needs of sex workers.

From this holistic approach, the Ukraine saw an increase in HIV knowledge and safer sex practices among sex workers from 40% in 2001 to 80% in 2003. The project staff also reported that there was a decrease in anal and vaginal intercourse, intimating that sex workers had reduced their risky sexual behaviours. The success of such programmes is dependent on the trust built between HIV workers and the SW community. The project in the Ukraine also facilitated the increase of medical uptake as previously sex workers had not been willing to access health services.

Similar programmes have been conducted in Calcutta, India. The results of this programme saw a drop in syphilis from 25% in 1992 to 8.76% in 2001. HIV rates were also reduced from 11.7% to 4.6%. The prevention unit of the NHP has started to implement similar programmes in Jamaica based on the programmes in India. However, no evaluations have been done yet on these programmes. NHP expects that a similar programme in Jamaica will address the issues and the risks surrounding SW HIV transmission from a holistic perspective. (National HIV Programme 2009)

There is documentation from Bolivia, Cote D'Ivoire and Dominican Republic which indicates that targeted interventions for SW resulted in a decline in the prevalence rate amongst the group. The interventions also included risk-reduction messages, as well as creating an enabling environment. (Maria Laga 2010)

A similar holistic approach is necessary to reach MSM. In the case of MSM the important thing is not only to access condoms but also lubricants. The use of social networks of MSMs to provide peer support to increase condom use has been seen to work both in the Black American and Latino communities in the USA (Juli-Ann Carlos 2010) and in MSM community in Bulgaria. (Yuri A. Amirkhanian 2003). This method involves the empowerment of key leaders in the various MSM networks and communities to provide the necessary HIV information. In the case of the Black American and Latino groups community leaders were chosen by the groups.

The NHP has started to implement a Men's Health Programme aimed to empower MSM thus increasing HIV and STI knowledge and condom use. As with the programme for SW this programme is in its preliminary stages and no evaluation has been done as yet.

Of note is that these holistic approaches are expensive to implement as they take both time and money to be successful. (UNAIDS 2006)

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Stages	Activity	Key sources of information	Result
#1: Synthesis of current goals, objectives, programs, policies, indicators, rules, regulations and approaches currently in place in Jamaica	Identify the goals related to HIV/AIDS	Government documents, e.g., National Harm Reduction Action Plan, National AIDS strategy. Decree 108.	Clear statement of the goal that we're driving towards  Identification of clarity/lack of clarity of goals
#2: Epidemiology of HIV/AIDS: problems, direct and indirect causes/risk factors, extent of the problem, special issues with HIV/AIDS in MARPS populations	Synthesis of problems, causes, direct and indirect risk factors across MARPS populations.	Collected documents, e.g., IBBS.  Interviews with key informants: WHO, FHI, UNAIDS, USAID, PEPFAR	Synthesis document  Consensus document
#3: Characteristics of MARPS and factors that affect supply and demand to those population groups: socioeconomic, cultural, care seeking, etc (who, what, where, when, etc)	Synthesis of characteristics of different MARPS groups with understanding of major factors affecting the spread of HIV and what influences that spread	Collected documents, e.g., IBBS.  Interviews with key informants: WHO, FHI, UNAIDS, USAID, PEPFAR	Synthesis document.  Consensus

<p>#4: Evidence based interventions and program approaches: hard evidence of what has worked and not worked in Jamaica. Examination of current coverage levels of those interventions and coverage levels required to achieve the desired impact.</p> <p>Assessment of M&amp;E approaches including review of indicators of program performance, effectiveness and impact.</p>	<p>Synthesis of evidence of effectiveness of different interventions directed at problems, causes, risk factors for each MARPS group.</p> <p>Data on coverage of all effective interventions.</p> <p>Gaps in knowledge</p> <p>Target coverage levels required for most effective interventions to achieve goals</p>	<p>Source documents and interviews: Health Policy Initiative, MSH, WHO, Abt Associates NHA work, FHI, PSI, UNAIDS.</p> <p>Will probably have to look at experience from the region through the AIDS Alliance and other sources.</p>	<p>Synthesis document</p> <p>Consensus on most effective interventions, baseline and target coverage levels, gaps in knowledge</p>
<p>#5: System requirements across the 6 health system building blocks (including demand) which would be required to deliver those critical interventions at the required scale. This includes potentially estimates of cost, depending on budget.</p>	<p>System requirements identified for each effective intervention</p> <p>Requirements across all 6 HS building blocks and demand</p>	<p>TBD</p>	<p>Synthesis paper</p> <p>Consensus</p>
<p>#6: System analysis/ assessment identifying the system bottlenecks that</p>	<p>Systems analysis for each effective intervention.</p> <p>Synthesis of bottlenecks</p>	<p>TBD</p>	<p>Synthesis paper</p> <p>Consensus</p>

would need to be overcome to deliver those critical interventions at the required scale.	by building block.		
#7: Recommended health system strengthening approaches across the 6 building blocks.	Recommendations	TBD	Paper laying out recommendations Consensus
#8: Recommended indicators, M&E approaches and learning agenda including potential learning and OR opportunities which could be considered	Recommendations	TBD	Paper laying out recommendations Consensus
Analysis of opportunities for integration and “shared HSS”.	Recommendations	TBD	Paper laying out recommendations Consensus
Summary recommendations	Recommendations	TBD	Paper laying out recommendations Consensus



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## Most at Risk Populations and Health Systems Strengthening

A project designed to ensure that Health Systems can better respond to and reflect MARPS/HIV issues/impact and reduce the transmission of HIV

Implemented by AIDSTAR-Two on behalf of USAID and the PEPFAR HSS Technical Working Group



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# What is AIDSTAR-Two

- AIDSTAR-Two, is a USAID funded program that focuses on capacity building in the HIV AIDS response .
- It primarily works by undertaking projects on behalf of USAID HQ / PEPFAR Working groups and USAID missions
- AIDSTAR-Two is not a new or separate INGO it is simply a way that USAID can implement projects without having to go through lengthy tendering processes.



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**AIDSTAR-Two is led by Management Sciences of Health (MSH)**  
who assembled a team to develop and implement projects on  
behalf of USAID

**AIDSTAR-Two Partners are;** International HIV/AIDS Alliance;  
Cardno Emerging Markets; Health & Development Africa, Ltd.;  
Initiatives, Inc.; Save the Children Federation; Religions for  
Peace

**To date projects have been implemented by;** MSH, Alliance and  
Cardno as they have had the required expertise for the work  
requested by USAID



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# Snapshot: AIDSTAR-Two Activities

- Capacity building assessments and activities with NGOs, networks, and public-sector institutions in six countries
- Published Position Paper: *Challenges Encountered in Capacity Building: Review of Literature and Selected Tools*
- USG surveys and assessments: IDU survey, Europe & Eurasia MSM assessment
- OVCsupport.net website (>1,800 unique users in one month after launch)
- PEPFAR technical workshops for IDU



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# What this Project is About

AIDSTAR-Two has been tasked by the Health Systems Strengthening Working Group of PEPFAR to:

- Investigate and make recommendations about how Health System and Community System Strengthening can better serve the needs of Most At Risk Populations to HIV/AIDS.
- The focus countries for the investigation are Jamaica and Vietnam



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# Objectives

- Identify the system weaknesses that hinder supply and demand of services for MARPs
- Determine system requirements for the delivery of effective minimum package of services to MARPs and corresponding supportive interventions – refer PEPFAR, UNAIDS, GFATM guidance
- Assess the importance and service delivery impact of health and community system strengthening activities for delivering key services for MARPs
- Outline a methodology to prioritize system strengthening interventions in various settings and document best practices in service delivery to MARPs
- Build consensus among stakeholders on the guidelines.



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# It's not Business as Usual

The HSS working group is concerned with this issue because:

- Increasing epidemics amongst MARPS
- Insufficient resources allocated or MARPS focused programs implemented
- Recognition that the nature of MARPS means many structural and systems barriers exist
- Scarce resources means we need highly focused interventions that have the greatest impact and we need to use those resources efficiently
- Highly focused programs and interventions need systems support to be effective
- As HIV becomes more integrated into wider health outcomes need to ensure that health systems can respond to the needs of MARPS



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In Jamaica AIDSTAR-Two is working with the Caribbean HIV/AIDS Alliance (CHAA) to investigate this issue and develop specific recommendations for USAID Jamaica on how Health and Community Systems can be strengthened to ensure that HIV incidence amongst MARPS is reduced.



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# Why Jamaica?

- Of the \$200m+ in HIV funding required for full implementation of the National Strategic Plan less than 20% is actually available and this is likely to reduce even further as Jamaica is recognised as a middle income country.
- Pefar, as a major donor to the HIV response in Jamaica in an environment in shrinking resources wants to make sure that its funding can have the greatest impact
- Therefore there is a need to consider where the greatest impact is and what needs to change structurally to enable that impact to take place



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# Why Jamaica?

But:

Good programs being developed, based on regional and global best practice and a recognition that we need to draw upon this base to develop stronger, more informed programs that have a measurable impact



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## Key Issues for Jamaica?

- Concentrated epidemics amongst MARPS
- Insufficient in depth data to help in decision making on setting specific targets and priorities
- Little impact analysis so not really clear what interventions actually make the difference
- Little costing / finance analysis to know what are the most cost effective interventions



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# Key concepts in our approach

- Causal analysis
- The vital few vs. the trivial many – the 80/20 rule
- WHO's six building blocks and the five policy “control knobs”
- Recognition that systems go beyond the formal HSS building blocks and encompass wider structural issues including Community Systems Strengthening



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# What is Causal Analysis

- The basic principle of causal analysis is to find root causes that you can treat rather than treating symptoms (which, as all doctors know, seldom effects a lasting cure).
- A *root cause* is the basic reason why something happens and can be quite distant from the original effect.



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# What is Causal Analysis

## Ask why five times

- The trick with seeking root causes is to keep looking.
- When you ask 'why' of something, you will get a nearby direct cause. If you keep asking 'why' of each answer, you will eventually get to a cause that you can act on. It is not always five times, but it may well be around this number.
- The key is just to keep asking until you get to a real 'aha' that you can treat.



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# What is Causal Analysis

*Sales figures are down.*

*Why? Because we are selling less.*

*Why? Because our customers do not want our products.*

*Why? Because our competitors have better products.*

*Why? Because we have not produced good products for a while.*

*Why? Because in the last change we significantly reduced research investment.*

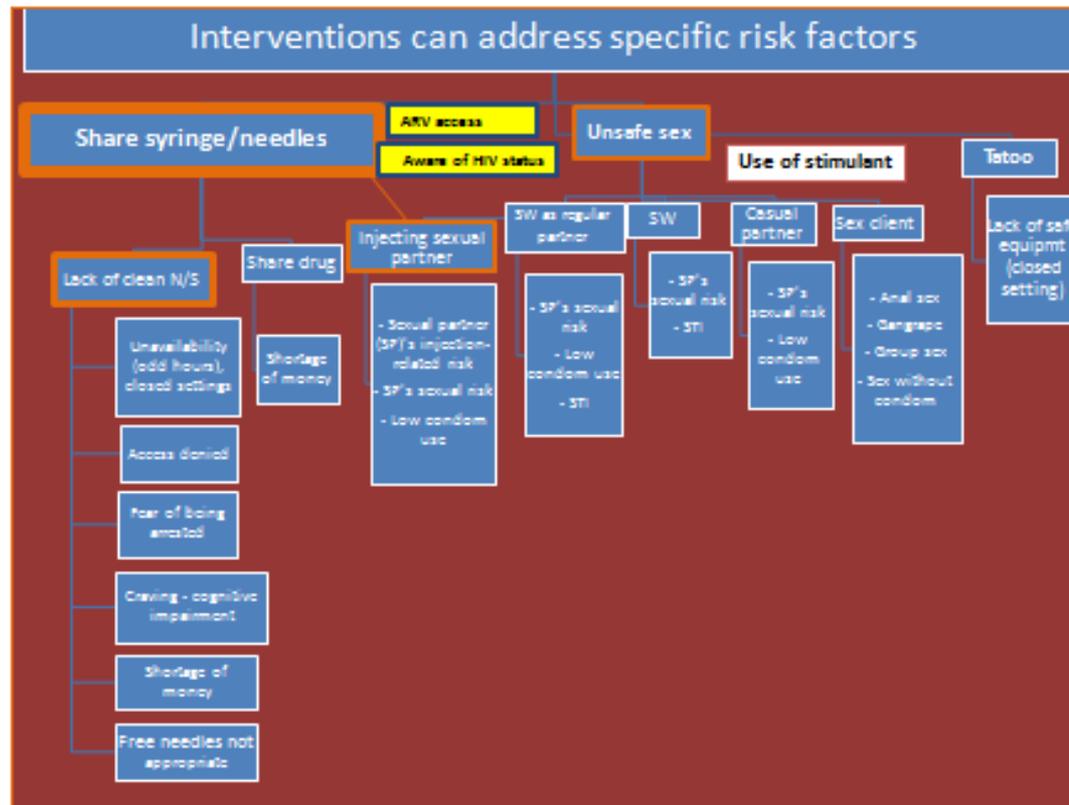


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# Causal Analysis eg



WORKING DRAFT



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# Causal thinking for MARPS

Questions we need to ask:

- What is the current incidence in MARPS and what is the target?
- What are the predominant risk factors that are driving transmission? Which are the major pathways?
- Which population groups have those risk factors and what are their characteristics?
- What interventions are most effective at reducing the major risk factors or that can interrupt transmission pathways? What are baseline coverage levels and what are target coverage requirements to achieve the target?
- What are the health systems requirements for high coverage and what are the bottlenecks that impede reaching those coverage levels?
- What system strengthening actions are most effective?
- How should we measure progress (indicators) that link HSS to reduced incidence?



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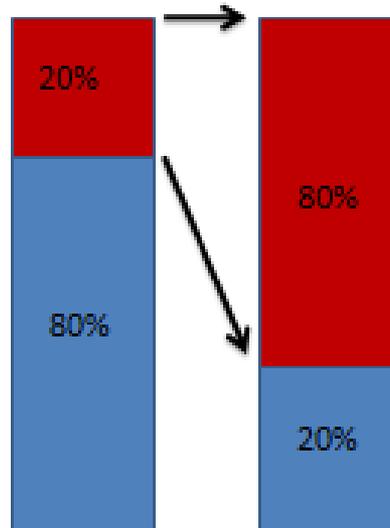
# 80/20: Achieving more with less

We can't do everything: Focus on the 80/20 problems, causes, risk factors, interventions

80% of the problem comes from 20% of the causes

80% of causes are driven by 20% of the risk factors.

20% of the effort produces 80% of the results.



80% of the impact comes from 20% of the interventions

80% of system improvements come from 20% of the system strengthening efforts.



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# What is the Health System?

- WHO has defined that the Health System is comprised of 6 “building blocks”
- Combined, these building blocks allow the health sector to function and deliver services



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# What are the building blocks?

- Leadership / Governance
- Service Delivery
- Health Workforce
- Medical Products, Technologies, Vaccines
- Health Financing
- Health Information System

# So what are the implications of HSS?

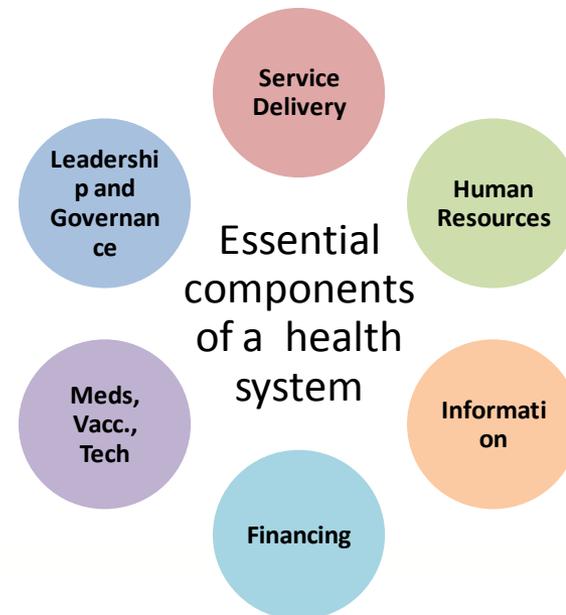


## Global Thought Leaders and Donors are focusing on HSS. What does this mean?

- **USAID:** Strategies needed to identify and address most critical health systems function needs
- **Global Fund:** Integration of health intervention programming on cross-cutting health systems constraints
- **WHO:** The best measure of a health system's performance is its impact on health outcomes

## WHO Framework for HSS

A health system consists of all organizations, people, and actions whose primary intent is to promote, restore or maintain health.





# Policy control knobs for changing system performance

Five key features of the health system which can be manipulated by policy makers and managers.

- When systematically applied have shown to influence the structure and function of the health system.
- They are a promising approach to improving health system performance for greater health impact.

# What are those control knobs?

1. Changing how **resources** are mobilized and allocated and how risks are pooled
2. Changing the **organization** of financing and the appropriate involvement of public and private sectors
3. Changing the **payment and incentive** structures for providers and consumers and modifying **costs of inputs**
4. Use of the **coercive power of government** through policy & regulation
5. **Influencing beliefs, preferences and behavior** of people, organizations and providers

Applied against system bottlenecks can improve system performance

## Health system bottlenecks

*Leadership and Governance*

*Health Information*

*Health Financing*

*Medical Products, Vaccine, and Technologies*

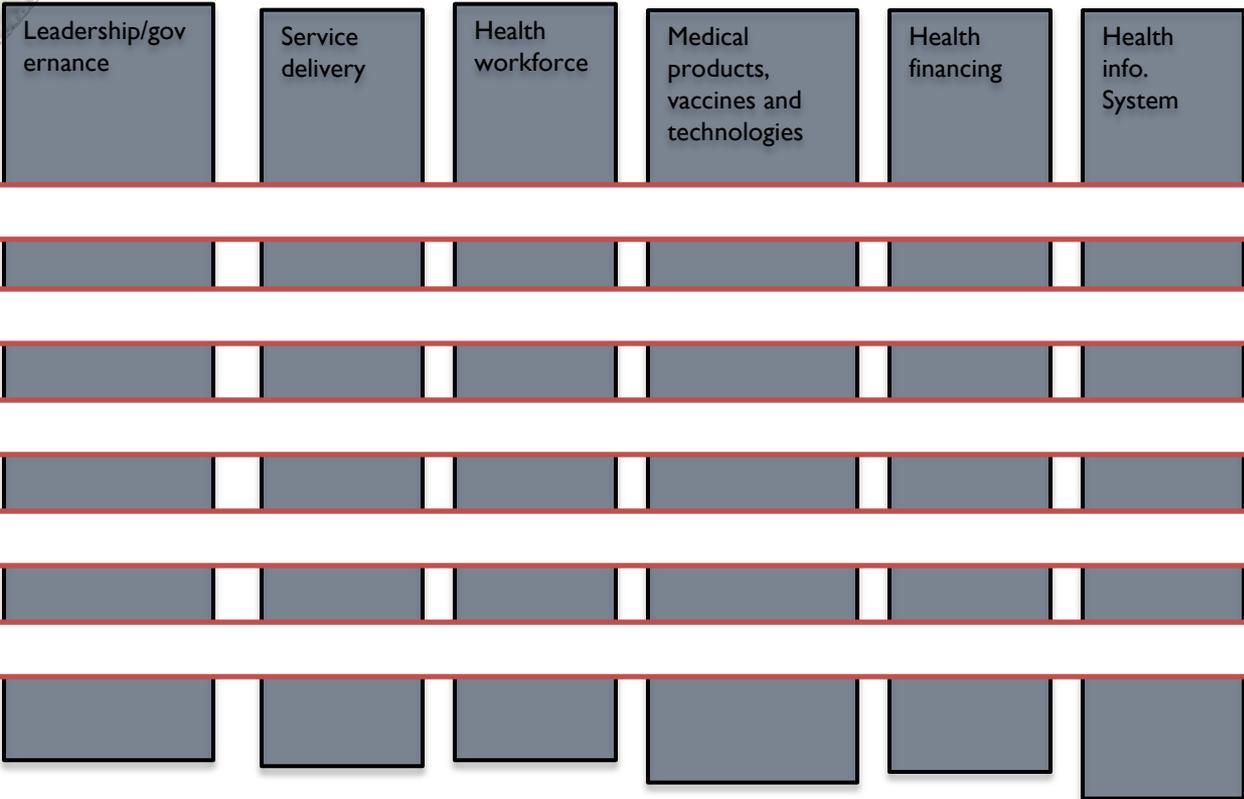
*Health Workforce*

*Health Services and Delivery*

# HSS results framework applied to reduction of HIV incidence in MARPS

Health system "pillars"

"control knobs"



Reduce AIDS  
related mortality

Reduce HIV  
transmission in  
MARPS



# Integrating causal thinking into HSS

## Epidemiological causal analysis

- Describe the desired outcome
- Describe the problems to be overcome
- Identify direct and indirect causes and risk factors
- Determine characteristics of the populations at risk
- Identify evidence based interventions to address causes and risk factors
- Define baselines and target coverage levels



## Health systems causal analysis

- Identify health system requirements for those interventions
- Describe health system bottlenecks, problems and causes, contributing factors
- Identify health system strengthening interventions
- Identify indicators of performance

**RESULT:** A tailored HSS program focused on achieving health outcomes.



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capacity for impact

# Methodology for Project

1. Understand the epidemiology of HIV transmission (people, place, time, risk factors)
2. Identify casual chain of HIV transmission and the critical points of intervention
3. Identify the vital few evidence based interventions appropriate for points of intervention
4. Determine system requirements and critical system bottlenecks
5. Determine system strengthening needs to overcome bottlenecks and improve effective coverage



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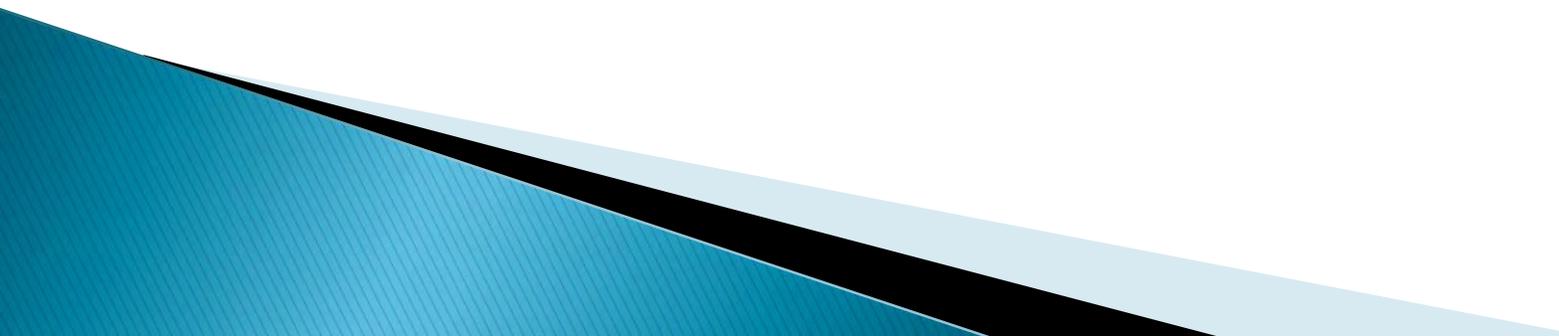
# What we would like to achieve today

- 1. Understand the epidemiology of HIV transmission (people, place, time, risk factors)**
- 2. Identify casual chain of HIV transmission and the critical points of intervention**
- 3. Identify the vital few evidence based interventions appropriate for points of intervention**
4. Determine system requirements and critical system bottlenecks (**get some initial pointers**)
5. Determine system strengthening needs to overcome bottlenecks and improve effective coverage

# Health Systems Strengthening for MARPS

Characteristics of MARP  
Presented by Renée Johnson  
January 12, 2011

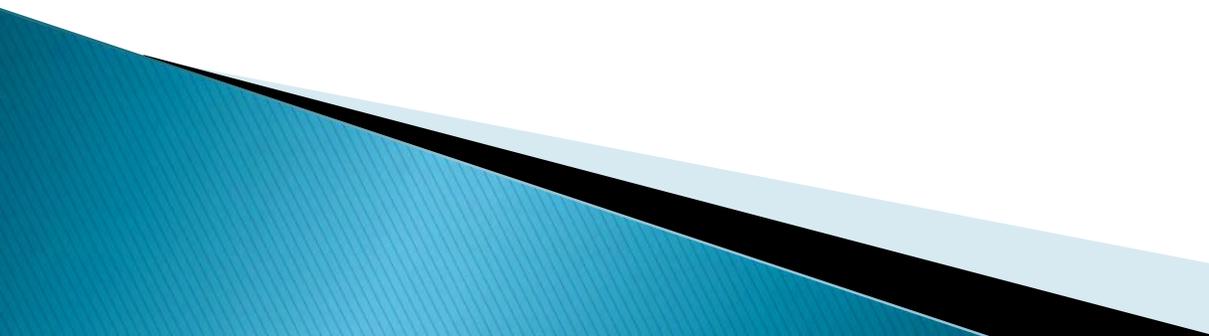
# Background

- ▶ Ministry of Health is guided by a strategic plan.
  - ▶ There is an HIV NSP for 2007–2012
  - ▶ Financing for the Health Sector is mainly from GOJ coffers
  - ▶ Approximately 5 % of GDP spent on Health
  - ▶ Financing of HIV mainly from GOJ and IDP
  - ▶ Only 30 % NSP is funded
- 

# Epidemiology

- ▶ **What we know**
- ▶ 80 % of all HIV/AIDS cases have a history of multiple sex partners
- ▶ Approximately 20 % of all persons with HIV have a history of sex with sex workers
- ▶ Approximately 28 % of cumulative HIV/AIDS cases have no apparent risk
- ▶ 90 % of HIV cases report heterosexual contact
- ▶ Only 43 % of men with HIV sexual orientation is actually known. 4% bisexual. 3.4% homosexual

# Epidemiology Cont'd

- 66% of HIV cases reported in urban areas—Kingston, St. James, St. Ann, St. Catherine
  - 74% cumulative HIV/AIDS reports between age group 20–49
  - 31 % HIV prevalence in MSM community
  - 5 % HIV prevalence in SW community
  - 5 % Homeless Crack Cocaine Users
  - 3.3 % Inmate Population
- 

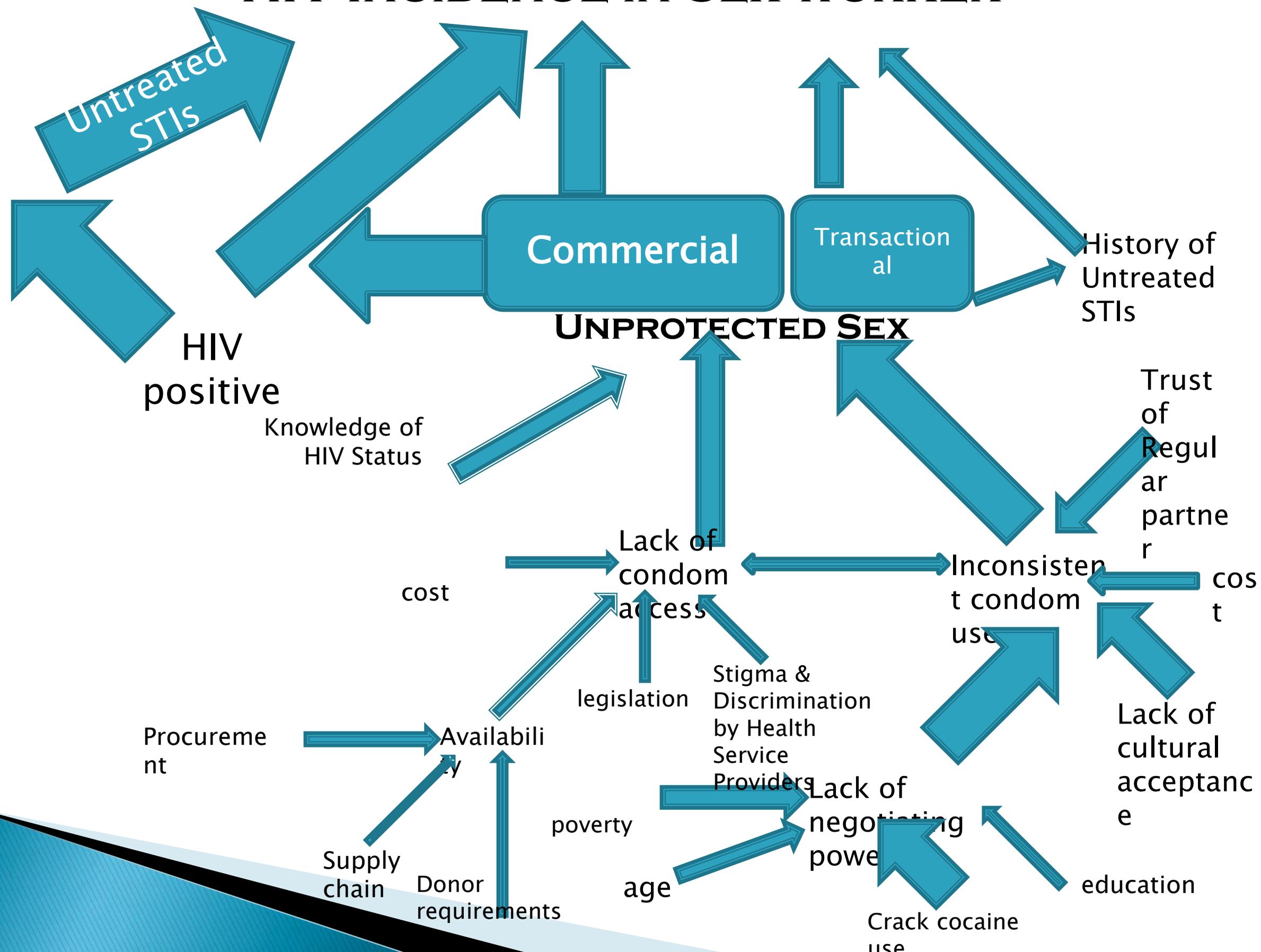
# Who are MARPs

- ▶ UNAIDS
  - ▶ Sex workers
  - ▶ Clients of Sex workers
  - ▶ Men who have sex with men
  - ▶ Injecting Drug Users
- 
- Jamaica
  - ▶ Sex workers
  - ▶ MSM
  - ▶ Inmates
  - ▶ Crack Cocaine Users
  - ▶ Out of School Youth

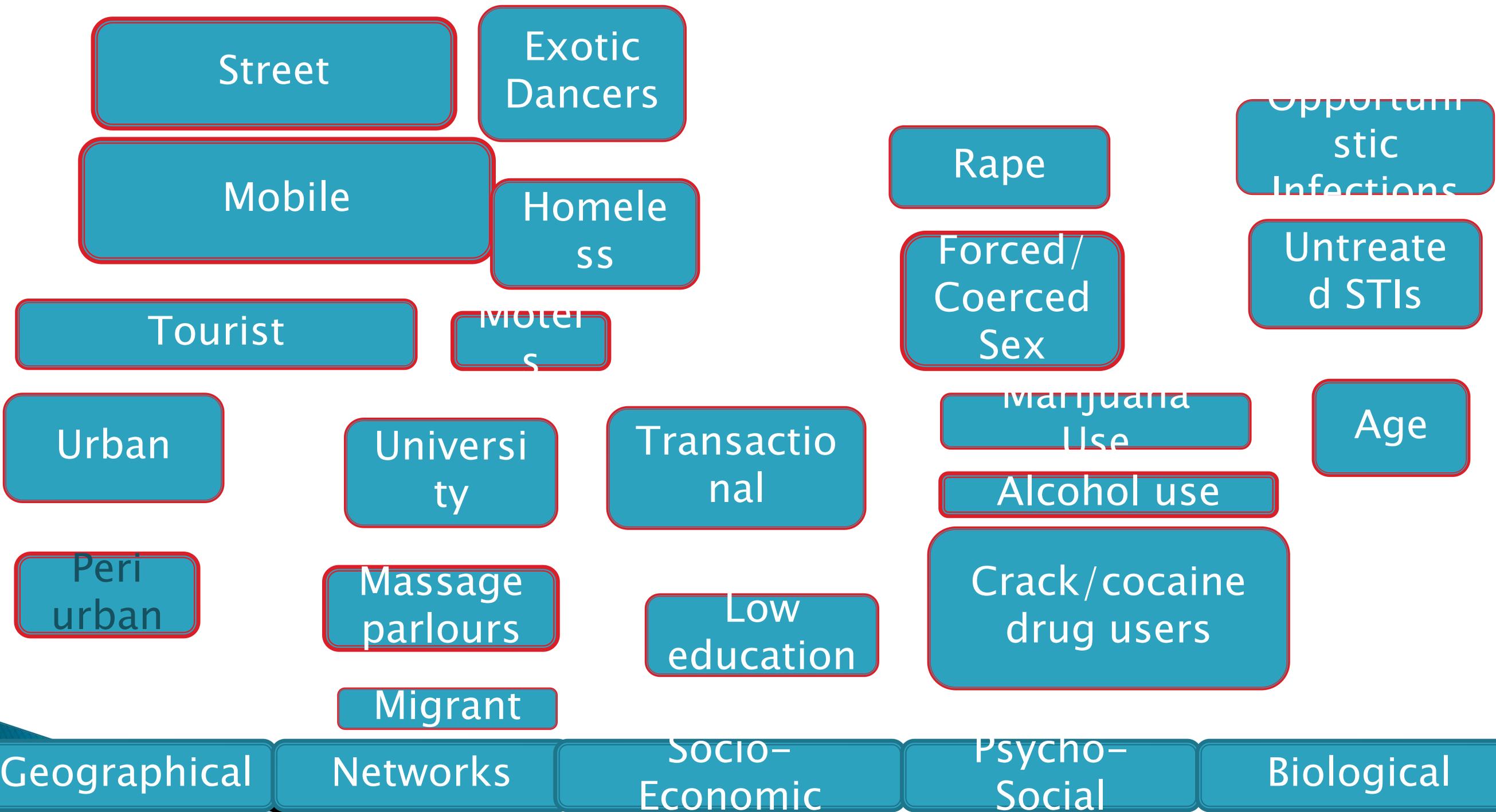
# Priority Areas

Priority Areas	Challenges that affect MARPs	Strategic Objectives that focus on MARPs
Prevention		<ul style="list-style-type: none"> <li>• Research based prevention efforts</li> <li>• Drug Abuse</li> <li>• Vulnerable Populations</li> <li>• Gender and Social Vulnerability</li> </ul>
Treatment and Care	-	<ul style="list-style-type: none"> <li>• HIV Testing</li> </ul>
Enabling Environment	<ul style="list-style-type: none"> <li>• MSM Stigma and Discrimination</li> </ul>	<ul style="list-style-type: none"> <li>• Identification and support for champions for change for other law reform and advocacy, which protect the rights of all Jamaicans including the vulnerable and the marginalized.</li> </ul>
Empowerment and Governance	-	-

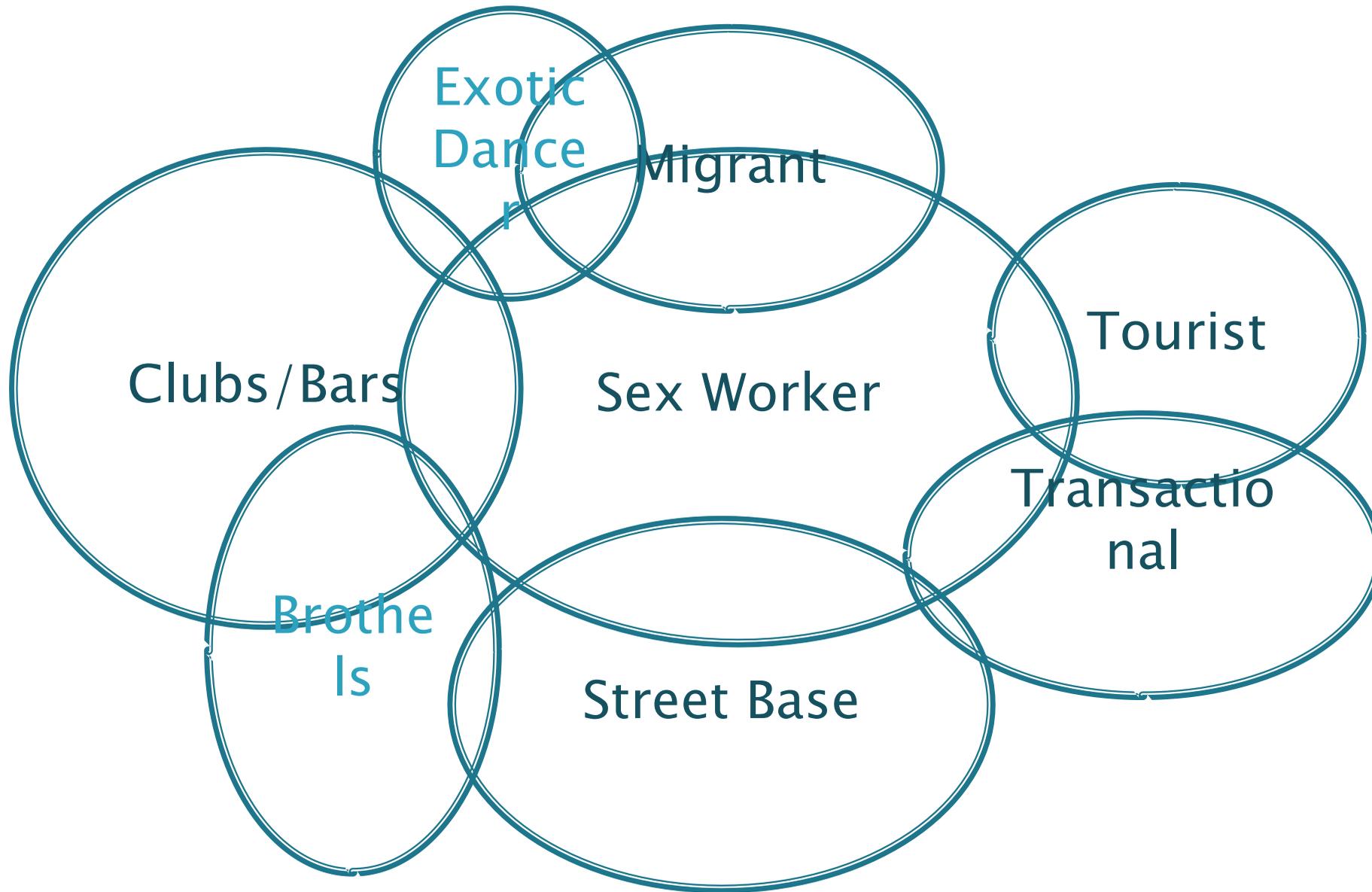
# HIV INCIDENCE IN SEX WORKER



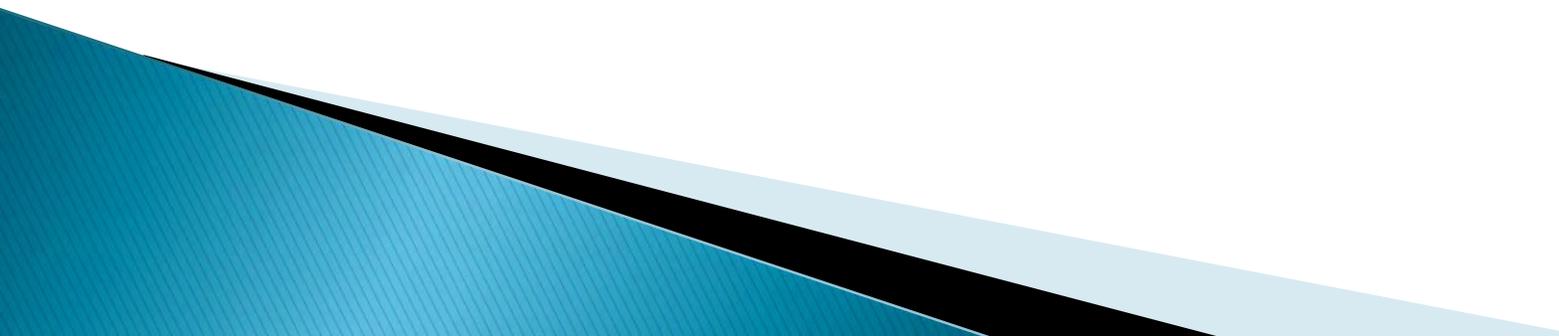
# Possible Characteristics of HIV Incidence in Sex Workers



# Sex Worker Network

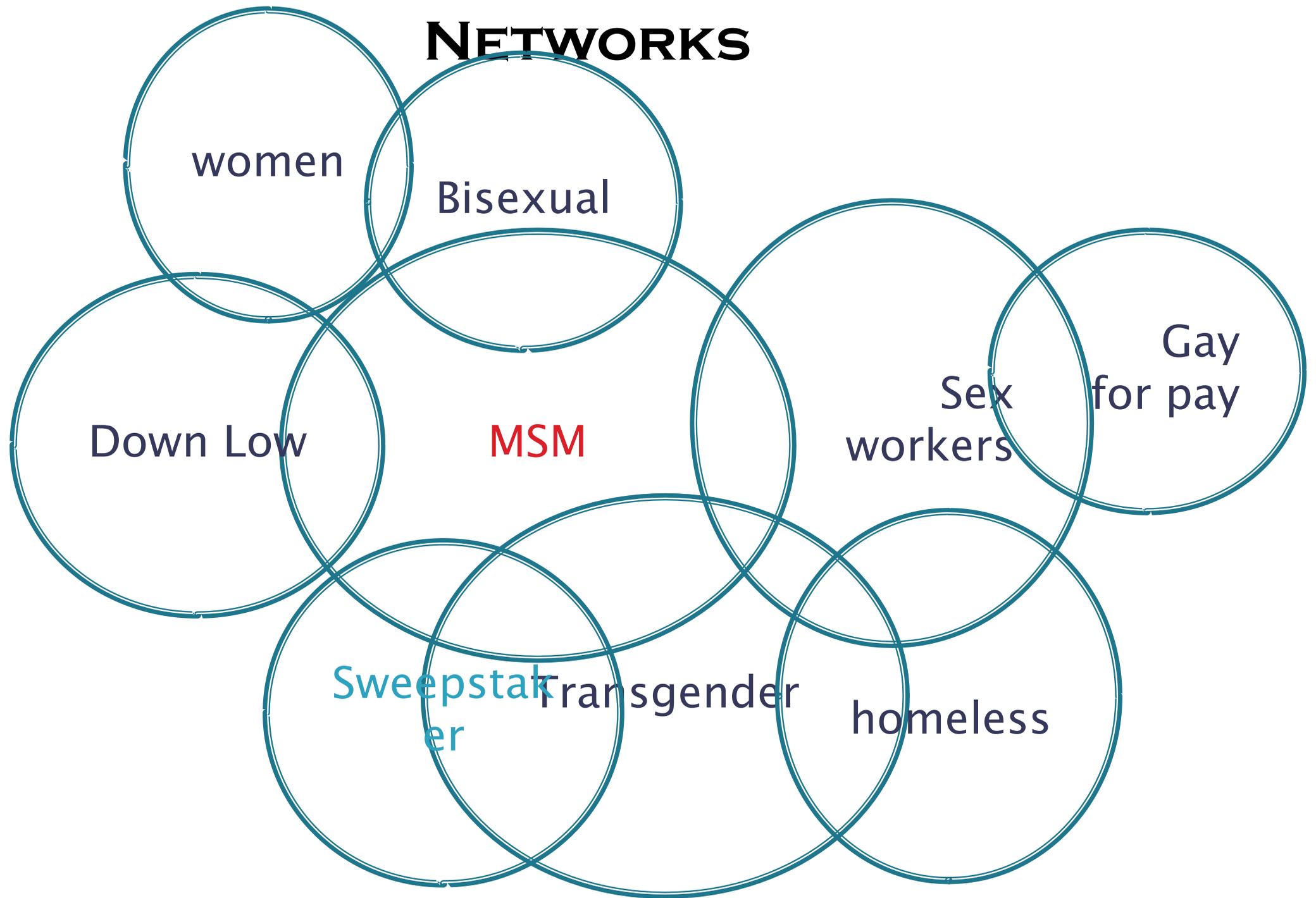


# Where Sex Workers

- ▶ Streets
  - ▶ Massage Parlours
  - ▶ Bars / Restaurants
  - ▶ Exotic Dancing Clubs
- 



# MSM NETWORKS



# Sub Populations of MSM

Sex workers

Transgender

Sweepstakers

Professional

School Boys

Gay for Pay (Giggolo)

Battyman

Middle Class

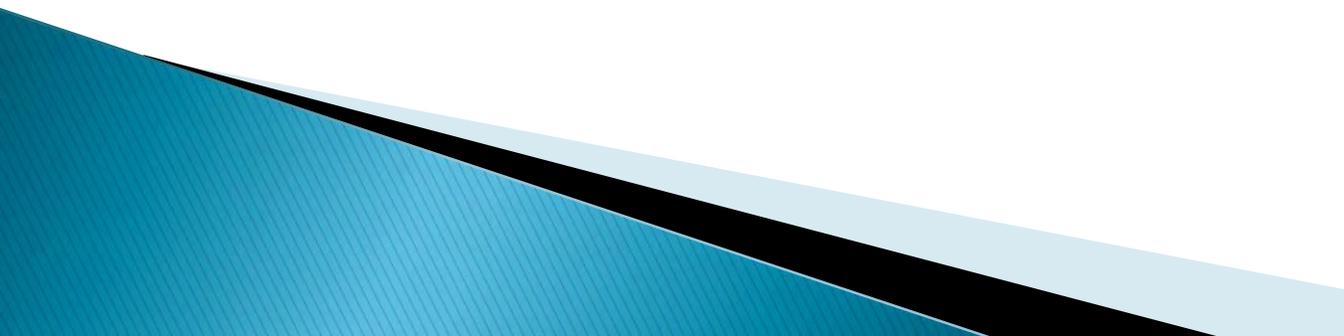
Bi-sexual

Upper Class

Street Based

Homeless

Down Low



# Risks for MSM

- Assuming female gender roles
  - Role of being receiver
  - Coercive sex
  - Physical abuse
  - Stigma and discrimination
  - Inconsistent condom use
  - Multiple sex partners
  - Transactional Sex
  - Untreated STI
- 