JAMAICA

HIV SUSTAINABILITY AND TRANSITION PLAN

FINAL REPORT

December 2020

PHAROS GLOBAL HEALTH ADVISORS

FOR

THE JAMAICA S&T COMMITTEE AND UNAIDS

MINISTRY OF HEALTH & WELLNESS

UNAIDS

Pharos Global Health Advisors

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Acronyms

AHF	AIDS Healthcare Foundation
ART	Antiretroviral therapy
ARV	Antiretrovirals
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control and Prevention, U.S. Government
CI	Case Index
CSO	Civil Society Organizations
CVC	Caribbean Vulnerable Communities Coalition
FSW	Female sex workers
GDP	Gross domestic product
GF	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GoJ	Government of Jamaica
HCJ	Health Connect Jamaica
HCW	Health care workers
HIV	Human immunodeficiency virus
HPP	Health Policy Project
HP+	Health Policy Plus
HRH	Human Resources for Health
HRSA	Health Resources and Services Administration, U.S. Government
HSS	Health system strengthening
HSTU	HIV/STI/TB Unit of the Ministry of Health and Wellness
ITF	International Transport Worker's Federation
JADS	Jamaica Anti-Discrimination System for HIV
JASL	Jamaica Aids Support for Life
JMD	Jamaican dollars
KAPB	Knowledge Attitudes Perception and Behavioral Survey
KP	Key populations
LAC	Latin American and the Caribbean
LGBTQI	Lesbian, gay, bisexual, transgender, queer and intersex.
LMIS	Logistics Management Information System
LTFU	Lost to follow-up
MDAs	Ministries, Departments and Agencies
MERG	HIV M&E Reference Group
MOHW	Ministry of Health and Welfare
MoU	Memorandum of Understanding
MSM	Men having sex with men
M&E	Monitoring and Evaluation
NAC	National Aids Committee
NASA	National AIDS Spending Assessment
NCDs	Non-communicable diseases
NFPB	National Family Planning Board
NGO	Non-governmental organization
NHF	National Health Fund

NHI	National Health Insurance
NHIS	National Health Information System
NPHL	National Public Health Laboratory
NSP	National Strategic Plan
OSY	Out-of-School Youth
PAHO	Pan-American Health Organization
PIOJ	Planning Institute of Jamaica
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PR	Principal Recipient
PrEP	Pre-Exposure Prophylaxis
PSE	Population size estimation
RBF	Results-based financing
RHAs	Regional Health Authorities
ROPs	Regional Operational Plans
RSSH	Resilient and sustainable systems for health
SR	Subrecipient
SRH	Sexual and Reproductive Health
SSR	Sub sub-recipient
S&T	Sustainability and Transition
TGW	Transgender women
TPA	Transition Preparedness Assessment
TRANS	Transgender people
TWG	Technical working group
UMI	Upper middle-income country
UNAIDS	Joint United Nations Program HIV/AIDS
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Programme
UNWomen	United Nations Entity for Gender Equality and the Empowerment of Women
USAID	United States Agency for International Development
UWI	University of the West Indies
VL	Viral load

Authors and Acknowledgements

This report was prepared for UNAIDS by Diana Gonzalez, Sandra McLeish, and Robert Hecht of Pharos Global Health Advisors. The authors thank Manoela Manova, Nertila Tavanxhi and Carl Schutte for their valuable support and feedback provided throughout the preparation of this report. The report has benefited from input from a wide range of stakeholders including members of the Steering Committee on Transition and Sustainability and others from the Ministry of Health and Wellness, Civil Society Organizations, PEPFAR and the Global Fund. All errors and omissions are our own.

Executive Summary

The Challenge of HIV Sustainability and Transition

Jamaica's HIV response has benefited from major donor and government support and significant gains have been made over the past decade. External support has predominantly come from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). New HIV infections have decreased by almost 10% since 2010, and 84% of people living with HIV (PLHIV) know their status, the highest percentage among English-speaking Caribbean countries.[1] Nevertheless, Jamaica is still far from achieving the second and third 90-90-90 targets and significant progress will be required to reach the global 95-95-95 HIV targets by 2030. The second and third 90s of the treatment cascade deserve special attention, as just 53% of PLHIV are accessing antiretroviral therapy (ART) and only 65% of those on treatment have suppressed viral loads.

It is crucial that Jamaica develop a prioritized Sustainability and Transition Plan to assume increasing domestic responsibility for its HIV program, preparing to transition efficiently while extending and sustaining the disease control gains that they have achieved.

In early 2020, Pharos Global Health Advisors was asked to facilitate the development of an HIV Sustainability and Transition Plan, in collaboration with the Steering Committee for Sustainability and Transition which includes representatives from the Ministry of Health and Welfare (MOHW), Ministry of Finance (MoF), Planning Institute of Jamaica (PIOJ), civil society, the private sector donors and UN agencies. The S&T Plan builds on earlier work including a Transition Preparedness Assessment conducted in 2017, which identified a number of transition risks but did not prioritize them or develop detailed actions to mitigate those risks, and an HIV investment case produced by the World Bank that estimated future costs of an expanded response but did not obtain country buy-in. This report translates analysis to action, focuses on a small number of priority issues and opportunities, and emerges from a highly engaged process with national stakeholders in the S&T Working Group. It is also directly linked to the new Jamaica HIV National Strategic Plan, providing a clear complementary chapter to the NSP on sustainability and transition.

As Jamaica faces the prospects of reduced Global Fund and PEPFAR support, this detailed action plan, including steps to mitigate transition risks and enhance the sustainability of the HIV response, must be implemented to buffer the effects of donor drawdown and eventual exit, something that could conceivably happen over the next six years (i.e., two three-year Global Fund allocation cycles).

Methodology

The S&T Plan followed a five-step process: preparatory document review and background phone interviews, consultations during an in-country mission, drafting the Sustainability and Transition Report, a virtual intersectoral workshop, and preparation and validation of final the report. The Pharos team also drafted a five-page summary to be used in the Jamaica HIV National Strategic Plan for 2021-25.

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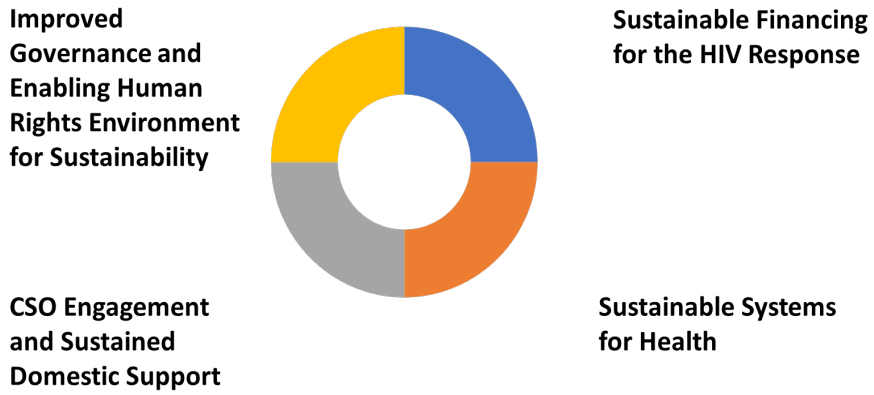
[1] UNAIDS (2016).

During the visit to Kingston in February 2020, the team met with key stakeholders including Ministries of Health and Finance, the National Health Insurance (NHI) Fund, CSO representatives including non-governmental organizations (NGOs) and community groups, implementing organizations, country-based staff from UNAIDS, and PEPFAR. A second mission was planned for later in the year; however, project plans were unexpectedly changed by the Covid-19 pandemic that broke out just after Pharos's first mission.

Pharos broke down the transition risks and corresponding actions required using the methodology developed by Aceso and APMG[2] for transition readiness assessments and the lessons learned in a synthesis review by Pharos of more than 30 country experiences[3]. This resulted in an analysis of risks and responses in four main areas: Governance, Financing, CSO Engagement, and Health Systems (see figure below).



Context of the HIV Response in Jamaica

Epidemiology and Program Performance

In 2018, there were an estimated 32,617 PLHIV in Jamaica. The incidence rate was 0.83 per 1,000 persons and HIV prevalence was 1.5%, down from 1.8% in 2017. The epidemic is concentrated among key populations, including TGW with a prevalence rate of 51.0%, MSM at 29.6%, homeless persons with 13.8%, inmates at 6.9% and FSW at 2.0%. Most PLHIV are concentrated in urban areas, with the prevalence highest among the parishes of St James, Kingston, and St. Andrew.

[2] Aceso Global and APMG, Guidance for Analysis of Country Readiness for Global Fund Transition, 2017
[3] Pharos Global Health Advisors, Global Synthesis Review of Sustainability and Transition Readiness Assessments, 2020.

Jamaica's current progress on the UNAIDS 90-90-90 targets stands at the following: 84% of PLHIV know their status, 53% of those are on treatment, and 65% of those are virally suppressed.[4] At the end of December 2019, almost 16% of PLHIV (5,300 persons) were unaware of their status.

Prevention. The National Family Planning Board (NFPB) has lead responsibility for HIV prevention in Jamaica. The NFPB has recently been reincorporated within the MOHW after being made a separate and autonomous body for several years. This should facilitate stronger integration of the prevention, treatment, and other components of the national HIV response. Almost 90% of the Government's prevention budget for 2019 was allocated to key populations. Jamaica's combination prevention programs for KPs, particularly MSM and TGW, include comprehensive services (outreach and communications, testing and counseling, supply of condoms and lubricants) delivered mainly by civil society organizations. These prevention services depend heavily on outside funding and only receive minimal domestic financial support. The public sector focuses mostly on prevention for the general population, using the classic mix of mass communications and targeted outreach through government health facilities.

Testing and Counseling. While the MOHW treatment cascade data shows that diagnosis of PLHIV is high, there are still issues with finding and diagnosing the remaining 16% of the HIV positive population. A recent study notes that most MSM (95.0%) and TGW (97.1%) have tested for HIV at least once in their lifetimes, yet only 50.5% of MSM reported testing in the recommended 6-month increments.[5] Providing patients with an alternative and confidential way to test for HIV such as self-testing kits needs to be supported by the MOHW, as kits are currently only found in private high-cost pharmacies.[6]

Treatment. As shown in the treatment cascade, of all persons diagnosed with HIV, only 58% are linked to care. To address this gap, Jamaica must intensify its efforts to develop new strategies to immediately initiate and keep people in treatment.[7] As echoed in the 2020-2025 National Strategic HIV Plan, and campaigns such as the recent return to care campaign, targeted strategies for linkage-to-care need to be reinforced in the coming years.[8] Any proposed solutions will need to consider ways to mitigate stigma and discrimination, a major barrier to linkage to care. Insufficient quality of care is an issue resulting in loss to follow up and lower rates of viral suppression, resulting from weak and inconsistent patient support services by care providers. Ongoing initiative by the private sector under a USAID-backed project may help to address this issue of quality of care.

Adherence. Patient lack of adherence is a pervasive issue within the Jamaican HIV program, yet remains not fully understood. The 2020-2025 NSP calls for studies on the profile of persons lost to follow-up (LTFU). Various steps have been taken to decrease LTFU including expanding clinic hours and establishing various protocols for healthcare workers to raise patient contact. Another issue affecting adherence to ART is the

[4] Jamaica National Treatment Cascade January 2020

[5] The 876 Study: Integrated Biological and Behavioral Surveillance Survey with Population Size Estimation Among Men who have Sex with Men and Transgender Persons in Jamaica, Ministry of Health Jamaica.

[6] Programmatic Review of Prevention Services and HIV Testing Modalities in Jamaica Draft V 2, Local Fund Agent

[7] National HIV Strategic Plan February 2020

[8] National HIV Strategic Plan February 2020

lack of timely lab results, which makes it difficult to know if patients are taking their medications regularly and achieving viral suppression. The National Public Health Laboratory (NPHL), responsible for viral load (VL) testing in Jamaica and regional reference laboratory for the Caribbean, has not been able to handle the level of VL testing for all PLHIV currently retained in care. The new NSP sets a goal to increase VL testing by 30,000 tests annually, and to allow for decentralization of VL testing to the Western and South Eastern Regional Health Authorities (RHAs). The PEPFAR-funded "U equals U" project supports this initiative in promoting treatment literacy for early initiation and adherence.

Health Systems

This report analyzes health systems challenges to HIV program sustainability in the areas of information systems, human resources, procurement and supply chain and human resources.

Regarding information systems, the major challenge is that data from HIV lab work (testing and diagnosis of HIV positive cases) and VL testing for those on ART are bifurcated and shared with different parts of the MOHW, making overall management of patients complicated. With assistance from the United States Agency for International Development (USAID), the MOHW aims to link the four main data areas: 1) Surveillance (managed by the National Surveillance Unit), 2) Prevention and Outreach (managed by the NFPB), 3) National Treatment (MOHW), and 4) the Repository (contact tracing) into a "Super Database".

To support HIV program design and management, Jamaica conducts periodic studies including the Integrated Biomedical and Behavioral Survey (IBBS), key population size estimates, and targeted analysis of risk groups and program responses. These critical studies depend almost entirely on donor funding and could be discontinued as external funding gradually winds down.

Several recent changes to the national procurement and supply management system, with the support of the National Health Fund have resulted in zero stock-outs in 2018 and lower prices for HIV commodities.[9] Throughout 2020, due to the global COVID-19 pandemic, the MOHW reported delays in receiving ARV shipments, which they said inhibited expansion of multi-month dispensing. They also noted insufficient storage space at individual pharmacies and proposed increasing the frequency of ARV deliveries to help mitigate the space issue.

In Human Resources (HR), the MOHW agreed starting in 2016 to begin covering HIV-related HR costs previously supported with GF and PEPFAR grants with an additional budget of J$500,000 per year.[10] Since then, the government has increased its share of the salaries of government HIV healthcare workers and has recently absorbed 46 positions from the GF and 64 from PEPFAR/USAID. Despite this progress, donors still provide salary support for peer educators, project managers/M&E officers, positions supporting human rights interventions and strategic information initiatives and service training.

[9] Absorption of ARV Medication Note (Global Fund)

Financing

The US Government (PEPFAR) and the Global Fund are the main sources of external financing for the national response, accounting for roughly 48% of total spending in 2017 while the GoJ share was 35.2%.[11] Over the past few years PEPFAR's allocation for Jamaica has risen and is expected to exceed $9.1M USD in 2020-21, while the Global Fund contributes approximately $4M USD annually. This continued reliance on PEPFAR and the Fund represents a serious sustainability and transition risk, since outside funding is uncertain and the annual projected funding needs for Jamaica's HIV response are expected to increase by $10.7M USD between 2015 and 2020, from $31.3M USD to $42.0M USD.[12]

The MOHW increased its recurrent budgetary allocations for the GoJ's HIV/AIDS control program from $403.5m JMD in FY18[13] to an estimated $864.6m JMD in FY20,[14] and expanded its capital investments during this period. Senior government officials from the health and finance ministry have indicated that the country is prepared and committed to increasing its budget for HIV in the coming year to replace donor support that may be waning as part of transition. Such increases, which are expected to maintain the share of the health budget allocated to HIV at less than 3%, are seen by finance officials as manageable, provided that the budget requests are well defined and justified in the Medium-Term Expenditure Framework.

While positive economic developments in Jamaica's economy in early 2020 signaled an increase in domestic investment for the HIV response, this may need to be revisited in the light of the COVID-19 pandemic and its impact on the Jamaican economy, government revenues and spending, and the need to spend a portion of the health budget to fight COVID-19. Financial sustainability of the HIV response, which already contained important challenges prior to 2020, will be more difficult for Jamaica to achieve in the post-COVID period.

Human Rights

Jamaica is committed to the promotion and protection of human rights through its agreement to a majority of the *Office of the United Nations High Commissioner for Human Rights'* core human rights instruments[15] and has worked to ensure non-discrimination of PLHIV through the National HIV and Workplace Policies. Despite these efforts, the current legal environment does not enable the national response to operate effectively. Several laws - such as the *Age of Majority Act*, the *Offenses Against the Person Act, Sexual Offenses Act*, and the *Dangerous Drug Act* - inhibit the program's ability to reach marginalized groups driving the epidemic. Legal barriers to HIV testing, prevention, and treatment not only increase the risk of individual transmission, but also heighten the probability of KPs spreading the infection to sexual partners and the general population. While progress in this area is recognized to be

[11] National AIDS Spending Assessment 2015-2017
[12] Global Fund Concept Note (JAM-H_ModTemplate_0_en.pdf)
[13] 2019-2020 Recurrent Jamaica Budget (program #10928)
[14] 2020-2021 Recurrent Jamaica Budget (program #10928)
[15] https://jis.gov.jm/govt-committed-to-protecting-human-rights/

challenging, stakeholders consider it to be essential for accelerating the impact of specific HIV interventions.

Governance

The National AIDS Council was set up more than 15 years ago to coordinate the overall response but has not been functional in recent years. The new NSP proposes to revitalize the NAC under the leadership of the Permanent Secretary of health. If this happens, the representation of CSOs will need to be guaranteed along with participation by key sectors such as Finance, Education, Labor, and the private sector.

Jamaica will also need to monitor and implement this S&T Action Plan. To do this, Jamaica has formed an S&T Steering Committee with members of the MOHW, MoF, PIOJ, UNAIDS, PAHO, NGOs and private sector (see Annex 1). The terms of reference for this group may need to be modified to ensure that it continues with monitoring, and that agreed actions have a clearly designated group accountable for results.

KPs and CSOs

Civil society organizations in Jamaica have worked on HIV for more than three decades. Over 15 CSOs participate in the HIV response, with a strong presence in Kingston. CSOs provide services for a wide range of Key Populations: youth, MSM), transgender persons, sex workers, migrants, inmates, PLHIV, homeless persons, drug users, women and girls, orphans and vulnerable children (OVC). Seven types of services are currently provided by these organizations: (1) treatment and care; (2) program coordination and management; (3) prevention; (4) advocacy; (5) social protection; (6) research; and (7) orphan and vulnerable children education.[16] It is estimated that CSOs provide more than 20 percent of all HIV-related services in Jamaica.[17]

The largest sources of funding for CSOs working on HIV in Jamaica continue to be the Global Fund and the US Government. CSOs also receive technical assistance from UN agencies including UNAIDS, UNICEF, UNDP and the UNWomen. While these CSOs have also been supported by the Jamaican government in the form of in-kind "subventions" (office space, condoms, and test kits, etc.), this represents a minimal fraction of CSO income and is not stable. Only recently the MOHW has shown willingness to formalize a social contracting mechanism for HIV to provide CSOs with financial sustainability after donor funds decrease. There were plans to launch a one-year pilot to have the initial contracts issued during the second half of 2020. However, the COVID-19 outbreak derailed those plans, and the new launch date has not been reset.

Private sector

With the support of the University of West Indies (UWI), Jamaica is implementing a PEPFAR-funded project via Family Health International (FHI360) to expand access to HIV prevention, treatment, and care through

[16] Jamaica Civil Society forum on HIV and AIDS (2020). Resource Mobilization Strategy 2020-2024.
[17] Myrie, T. 2019. Legal and Regulatory Assessment for Government funding of civil society organizations to deliver HIV services in Jamaica. Washington, DC: Palladium, Health Policy Plus.

the engagement of private health sector. The motivation of this project, Health Connect Jamaica (HCJ), is to provide an alternative solution to the limited physical and human resource capacity of the public sector to test and treat the additional PLHIV needed to close the treatment gap.

The project aims to increase quality and quantity of services.[18] It is estimated that the private sector could reach 25% of PLHIV. The target population comprises newly diagnosed, never linked (never exposed to ART), and lost-to-follow up patients. The private sector initiative will pilot PrEP and HIV self-testing as new prevention methods. In July 2020, this project was officially endorsed by the UWI and MOHW and moved to the roll-out phase after a pilot in the metropolitan areas of Kingston and St. Andrew in 2019/2020. By December 2020, the project had presence in three health regions (South East, South West and the Western) and preliminary results show that the project was able to enroll 230 clients, achieve 88% linkage to care and 90% viral load suppression. In terms of its sustainability, this intervention is expected to be fully rolled-out by the MOHW and given its cost (~ JMD 30,000 ($210 USD) per virally suppressed patient) it could be potentially funded by a future National Health Insurance scheme.

Main Transition Risks and Recommendations

As a result of extensive research, interviews, and consultations, a set of eight major risks to HIV program sustainability and transition emerged from the broader analysis summarized above. For each risk, several priority recommended actions were also identified. These actions are listed in a Transition Roadmap (see Chapter 5) along with details on specific activities required, the lead responsible agency and the timetable for implementation, as well as suggested monitoring indicators. The table below simply highlights the main actions needed to respond to the identified risk, while the Roadmap matrix in Chapter 5 gives greater details. As the government embarks on each area of the Roadmap, e.g., self-testing and PrEP for MSM, expanding viral load testing, operational plans and budgets need to be developed to guide implementation. This is already happening in some areas such as social contracting with CSOs.

[18] The HIV Private Sector Network in Jamaica. A proposal for the model: structure and functions (August, 2019)

Sustainability and Transition Risks	Recommended Roadmap Actions
A. Sustainable Systems for Health	
Risk 1. If linkage to care and adherence to ART does not increase and VL is not timely and extensively reported, fewer patients will achieve viral suppression, leading to failure to achieve the third 90	1.1 Monitor linkage to care and support extended work of case managers and patient navigators. Use public, NGO, and private sector providers to expand coverage.
	1.2 Raise the throughput capacity of National Public Health Laboratory system by strengthening Regional Laboratories for timely and effective Viral Load testing.
	1.3 Decrease LTFU of ART patients through rapid treatment initiation immediately upon receiving test results and quality adherence counseling by CSO and private providers.
	1.4 Support and monitor the performance of HCJ (private health sector engagement project) and develop a plan for its long-term sustainability beyond donor funding
	1.5 Document how social support is currently provided to PLHIV and identify opportunities to increase its performance and sustainability
Risk 2. If the MOHW does not develop national capacity to manage an integrated health information system and strategically use the reported information, there is a large risk of losing M&E capacity for key HIV indicators, which will undermine the country's ability to plan and manage its national HIV response effectively and efficiently.	2.1 Ensure that MOHW HIV unit has in-house capacity to manage its strategic information databases, reducing donor dependence for key positions and specialized expertise
	2.2 Complete the process of systems alignment for improved interoperability and strengthening of information systems, closing data gaps.
	2.3 Promote use of strategic information for comprehensive just-in-time program and patient-level management
B. CSO Engagement and Sustainable Domestic Support	
Risk 3. If the GoJ does not create an institutionalized, transparent and financially sustainable mechanism to transfer resources to CSOs (via "Social Contracting"), key activities currently funded by donors are at risk of being halted and disrupted in the face of decreasing external funds (90% financing of CSOs by PEPFAR and Global Fund).	3.1 Implement and evaluate a CSO social contracting mechanism pilot led by the MOHW, gradually increasing its funding to replace donor funding for CSOs, reaching 100% domestic financing within the next 3-4 years.

C. Sustainable Governance and Enabling Human Rights Environment for Sustainability	
Risk 4. If the HIV response does not have a semi-permanent and legally-authorized body to lead the HIV response and does not staff, fund, and politically support such a body, Jamaica will not be able to follow an accelerated path to a sustained, efficient and effective HIV program	4.1 Strengthen the coordination of the national HIV response by appointing an appropriately empowered and staffed national AIDS council/committee.
	4.2 Appoint and maintain a Sustainability and Transition technical working group/committee to oversee the S&T Plan, once endorsed by the GoJ.
Risk 5. If Jamaica continues to fail to address adequately Stigma and Discrimination (S&D), PLHIV will continue to face limited access to services undermining efforts to reach 90-90-90 targets.	5.1 Promote the adoption of an anti-discrimination law.
	5.2 Implement a National Human Rights Strategy that considers: (1) the creation of a National Human Rights Institute; (2) strengthening the human rights and gender components in the HFLE curriculum; (3) implementation of permanent national human right campaign; and (4) ongoing sensitization trainings for healthcare providers, legal operators, security forces, teachers, and parents
D. Sustainable Financing for the HIV Response	
Risk 6. If GoJ funding for HIV prevention (both delivered by CSOs and by the MOHW/public sector) remains insufficient and does not reach the most at risk populations (especially MSM), total spending in prevention will continue to be heavily reliant on donors, putting at risk the gains made to date and reducing likelihood of achieving the first 90.	6.1 Shift from donor to government financing of social contracts with CSOs using sustainable sources (approx. US$ 4 million a year at present)
	6.2 Increase national financing of HIV prevention services delivered by MOHW/public sector, reduce donor dependency.
	6.3 Implement and sustain effective interventions to reach the most at risk MSM population, such as self-testing and PrEP, and explore and implement action for CSOs to extend their reach to MSM
Risk 7: It will be challenging for the GoJ to increase its budget allocations for AIDS treatment as the number of persons enrolled in ART rises to reach the 90-90-90 targets. The treatment budget could nearly double in the next five years as the country moves from having 49% of its PLHIV on treatment to the goal of over 81% by 2025	7.1 Conduct scenario planning to project future funding needs for treatment and incorporate these in the MTEF and annual budgets agreed between MoF and MOHW. Simultaneously utilize international competitive procurement to obtain favorable ARV prices
Risk 8. If other competing diseases (including Covid-19) start demanding more public resources as part of future National Health Insurance, HIV budget lines could be reduced – unless HIV is seen as part of the NHI benefits package.	8.1 Ensure that HIV figures prominently in future National Health Insurance package definition and in NHI financing

Next Steps

Jamaica has made substantial progress over the past decades in the fight against HIV. Both prevention and treatment services have expanded as a result of the combined efforts of government, CSOs, and the private sector. The government has taken over financial responsibility for portions of the program, including paying for treatment services. These efforts must be sustained and further strengthened.

At the same time, the long-term prospects and sustainability of the response are unclear. This Sustainability and Transition Action Plan report provides a framework to understand the current situation and critical challenges for the short and medium-term. It identifies the strengths and weaknesses of the national HIV program, highlighting the 8 key risks to an effective and sustainable response. This report also elucidates 18 mitigation actions that can procure a smooth transition, especially as support from the Global Fund and PEPFAR wanes.

The recommended actions in this report need to be incorporated in the government budgets, Global Fund grant proposals, and PEPFAR Country Operational Plans, to ensure that they are backed with the needed investments and high-level political support. The S&T Steering Committee and the revamped National AIDS Council can provide a solid governance framework for leading, implementing, and monitoring the S&T Work Plan enclosed in this report. It is recommended that the Steering Committee develop a practical operational plan for 2021, building off the Work Plan included here.

To continue the progress towards HIV elimination, the GoJ must expand budgetary support for the national HIV program (specially to finance the activities of CSOs using results-based contracts and payments and finance an expanded treatment effort); intensify focus on overcoming stigma, discrimination, and other barriers; promote greater integration among the government, NGOs, and the private sector; and sustain high level political support.

To do this, the government must incorporate the main findings and recommendation in this Sustainability and Transition Report in the new NSP and in the new Funding Request to the Global Fund that is to be prepared in the first half of 2021.

If these actors in Jamaica implement the mitigating actions recommended in this report, Jamaica will be better positioned for a smooth transition from donor support to sustainable self-financed HIV response.

1. Introduction

1.1 The Challenge of HIV Sustainability and Transition

Jamaica's HIV response has benefited from major donor and government support and significant gains have been made over the past decade. New HIV infections have decreased by almost 10% since 2010 and 84% of people living with HIV (PLHIV) know their status, the highest percentage among English-speaking Caribbean countries.[19] The response is guided by the 2014-2019 National Integrated Plan for Sexual and Reproductive Health and HIV, while the 2020-2025 National HIV Strategic Plan is under approval.

Despite this progress, Jamaica is far from achieving the second and third 90-90-90 targets. According to the most recent figures, among those PLHIV who know their status, just 53% were accessing antiretroviral therapy (ART) and only 65% had suppressed viral loads. Key Populations (KP) bear the largest HIV burden with an HIV prevalence of 51% among transgender women (TGW)[20], 29.6% among men who have sex with men[21] – the highest prevalence rate for men having sex with men (MSM) in the Caribbean[22] -- 13.8% among homeless persons,[23] 6.9% among inmates at 6.9%[24] and 2.0% among female sex workers (FSW).[25] Men who have sex with men and female sew workers experience severe stigma, discrimination, and criminalization in Jamaica leading to hesitancy in accessing care and treatment.[26]

Undoubtedly one of the biggest changes to the Jamaican HIV response was the advent of external assistance which arrived predominantly through the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). The National AIDS Spending Assessment (NASA) 2015-2017 indicates that the investments of these two donors account for nearly half of the national response (48% as recently as 2017).[27] Moreover, in 2017 international sources including the Global Fund and PEFPAR contributed $9.9 million USD (55%)[28], public domestic sources $6.4 million USD (36%) and private domestic sources $1.6 million USD (9%)[29]. Additional external aid—through the Joint United Nations Program HIV/AIDS (UNAIDS) and the Pan-American Health Organization (PAHO)

[19] UNAIDS (2016).
[20] The 876 Study: Integrated Biological and Behavioral Surveillance Survey with Population Size Estimation Among Men who have Sex with Men and Transgender Persons in Jamaica, Ministry of Health Jamaica.
[21] Idem.
[22] UNAIDS (2016); AIDSmap, (2018)
[23] HIV Risk and Gender in Jamaica's Homeless Population
[24] Bio-Behavioral Surveillance Survey of Inmates in Jamaica, Dra Althea Bailey, (2019)
[25] The 4th (2017) Generation Surveillance of Commercial Sex Workers Female Patrons and Workers of Sites where Persons Meet Sex Partners or Participate in Sexual Activity in Jamaica
[26] UNAIDS (2018).
[27] 2015-2017 Jamaica National AIDS Spending Assessment (2018)
[28] PEPFAR reports support of about USD 8 million in FY20 and anticipates providing more than USD 9.1 million in FY21.
[29] GAM (2018).

which deliver key technical assistance—has also contributed significantly to Jamaica's programmatic gains. Furthermore, local stakeholders not affiliated with the Government of Jamaica (GoJ), such as the AIDS Healthcare Foundation (AHF) and several civil society organizations (CSOs) have collaborated to strengthen and focus the coverage of the national response.

In 2021 PEPFAR is expected to spend over $ 9 million USD while the GF will provide about $ 4 million USD. As the priority country for the PEPFAR Caribbean Regional Program, Jamaica is receiving 65% of the total PEPFAR support to the region. Among these investments, prevention and innovative testing for key populations are especially at risk to possible winding down of external resources. At the same time, the government's allocation will need to rise to meet an increase in total resource needs to $ 28 million USD or more to cover the expanding number of PLHIV who need to be enrolled in treatment.[30]

Jamaica is classified as an upper middle-income country (UMI) and, according to the Global Fund, has a "high" HIV burden. This UMI status combined with an HIV burden that is not "extreme" means that Jamaica will eventually become ineligible for Global Fund funding and will need to transition to a predominantly domestically funded response. Global Fund funding to Jamaica has already been significantly reduced with a 40.5% decrease in funding from the 2010-2013 grant to the 2014-2017 grant, and a further 15% reduction between the latest two country allocations (2017-2019 vs 2020-2022). While the next allocation including regional multi-country grants and special initiative resources may equal or exceed the current allocation, the overall trend is downward and future external funding prospects remain uncertain.

Reliance on external assistance is unsustainable in the long term. Although external aid is expected to continue for the next 5-10 years, Jamaica is moving closer to Global Fund transition while funding from PEPFAR depends on a host of uncertain factors, although PEPFAR has received strong bipartisan support across multiple presidential administrations. Future annual funding decisions may be influenced by the state of the US economy and budget, as well as political priorities. To mitigate these uncertainties, the GoJ has been proactive in planning for the sustainability of the nation's HIV response. This process began in 2013 with financial and programmatic sustainability assessments from both the World Bank[31] and the Global Fund,[32] respectively.

Several steps have already been taken to ensure a smooth transition and longer term sustainability of the national HIV program. The main action is that the GoJ gradually absorbed the ARV and essential commodities procurement becoming completely self-sufficient after 2018. In addition, a UNAIDS sponsored Transition Preparedness Assessment (TPA) was conducted by Curatio International in 2016 and published in 2017, where several transition risks that would impact Jamaica's HIV response were identified. The TPA also made preliminary recommendations to mitigate these risks. However, the TPA's

[30] AmfAR (2015).
[31] Assessing the Financial Sustainability of Jamaica's HIV Program (2013)
[32] Sustainability Review of Global Fund Supported HIV, Tuberculosis and Malaria Programs (2013)

prioritized recommendations have not yet been translated into a practical "roadmap" or plan of actions to support HIV program sustainability and transition.

This report and the S&T Plan contained in it builds on earlier work including the TPA conducted in 2017, which identified a number of transition risks but did not prioritize them or develop detailed actions to mitigate those risks, and an HIV investment case produced by the World Bank in 2015 that estimated future costs of an expanded response but did not obtain country buy-in. This report translates analysis to action, focuses on a small number of priority issues and opportunities, and emerges from a highly engaged process with national stakeholders in the S&T Working Group. It is also directly linked to the new Jamaica HIV National Strategic Plan, providing a clear complementary chapter to the NSP on sustainability and transition.

Against this backdrop, the Jamaica HIV Sustainability and Transition Working Group, chaired by Ministry of Health and Welfare (MOHW), the Ministry of Finance and CSOs, and with the support of UNAIDS, commissioned Pharos Global Health Advisors to facilitate development of a detailed HIV sustainability and transition (S&T) action plan, to align with and be part of the new HIV National Strategic Plan (2021-25) and Jamaica's next grant submission to the Global Fund. This report can help to translate the risk analysis into a practical plan. As Jamaica faces the prospects of reduced Global Fund and PEPFAR support, this action plan including steps to mitigate transition risks and enhance the sustainability of the HIV response, must be implemented to buffer the effects of donor drawdown and eventual exit, something that could conceivably happen over the next six years (i.e., two three-year Global Fund allocation cycles).

1.2 Objectives

The key objectives of the HIV sustainability and transition planning assignment to be conducted by Pharos Global Health Advisors, in close consultation with the Jamaica HIV S&T Committee, are to:

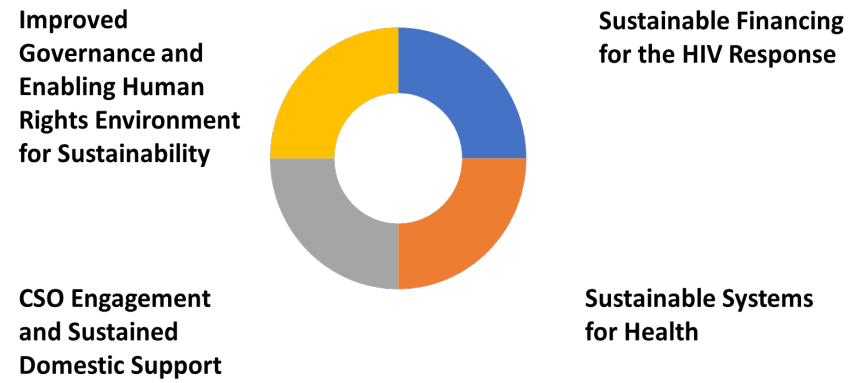
- Analyze current donor support to Jamaica's HIV program and the transition risks that were identified in the TPA posed by the winding down of donor support, focusing on the epidemiological situation, health system response, role of civil society, domestic and external financing status and prospects for the coming years, and enabling environment, and from these risks identify key risk areas that need urgent action to ensure sustainability and successful transition, in consultation with country stakeholders.
- Based on this analysis and consultative process, develop a full set of recommendations to mitigate risks to sustainability and transition.
- Guided by the Jamaica S&T Committee and UNAIDS, engage the country's stakeholders to prioritize practical actions to take in the short and medium term (3-5 years), covering implementation arrangements, costs, and monitoring indicators in the various areas (e.g., HIV service delivery, financing, information systems, procurement, management, and governance), as Jamaica moves progressively to increased self-sufficiency while strengthening the sustainability of the national response.

1.3 Methods and Process

The approach to development of an HIV S&T Action Plan for Jamaica followed the methodology that Pharos has refined over the past three years in multiple countries of Latin America, Asia, and Africa, building on the standard S&T tools crafted by Aceso and APMG in 2016.[33][34] More explicitly, the consultations and analysis used the optional modules from the Aceso/APMG guidance document, leaving aside the core modules repeating information contained in the TRA and other national documents.

For Jamaica, the methodology required updating risks and reclassifying them into four domains that help to capture the main S&T challenges and the search for practical solutions: (a) Improved Governance for sustainability: Governance, Political Will, and Human Rights; (b) Sustainable Financing; (c) Sustainable Systems for Health (e.g., human resources for health, service delivery, and supporting services including information systems, procurement and supply chain, surveillance and laboratories); and (d) CSO Engagement and Sustained Domestic Support which includes the analysis of key Populations: CSOs landscape and Social Contracting as an avenue for domestic financing. See the Figure below. These four domains encompass the sustainability and transition risks facing middle income countries such as Jamaica and provided a strong framework for analysis, formulation of recommendations, design of an action plan, and dialogue and consensus building.

Figure 1. The Four Domains of Sustainability and Transition Risks and Solutions



To conduct this analysis and plan development, the Pharos team worked closely with the S&T Committee and national stakeholders, plus the key donor partners, to carry out a five-step process:

Preparatory Stage (January to 15 February 2020): In this stage, the Pharos team gathered as much information as possible through interviews and other engagement with key country stakeholders and an exhaustive desk review to better understand Jamaica's HIV program and steps that have already

[33] Guidance for Analysis of Country Readiness for Global Fund Transition, Aceso Global/APMG 2017.
[34] Diagnostic Tool on Public Financing of CSOs for Health Service Delivery (PFC), Aceso/APMG 2017.

been taken to prepare for transition. This included a desk review of Global Fund, PEPFAR, and other donor documents (concept notes/funding requests, grant budgets, performance frameworks, progress reports, evaluations, Regional Operational Plans - ROPs) and other key materials such as national strategic plans, health sector budgets, health and HIV expenditure reviews, epidemiological and financial projections, evaluations conducted by other relevant organizations, laws and regulations related to work with key populations, and factors affecting potential or current government funding of CSOs.

In-Country Assessment Mission (16-22 February): The in-country mission helped to validate findings from the desk review and begin to identify mitigating actions for the sustainability and transition risks. The mission focused on consulting with all stakeholders, gathering additional data to support S&T risk analysis and definition of mitigating recommended actions and activities, and on prioritizing these actions and activities based on systematic criteria (expected impact, feasibility of implementation, etc.) to be incorporated in the draft S&T Action Plan.

During the mission, the team met with key stakeholders including Ministries of Health and Finance, the National Health Insurance (NHI) Fund, CSO representatives including non-governmental organizations (NGOs) and community groups, implementing organizations, and country-based staff from the UNAIDS, PAHO, and PEPFAR. Based on the document review and the information collected during the mission Pharos selected a short list of updated risks based on urgency, impact, and feasibility criteria. At the end of the mission (February 21, 2020), the Pharos team held a debriefing meeting where a short list of updated risks was validated and possible recommendations for the S&T Action Plan were discussed by key stakeholders. The Permanent Secretary of the MOHW attended this debriefing meeting and he agreed on the list of prioritized risks and recommendations.

Draft Report/S&T Action Plan (March-August 2020): The draft report synthesized findings from the desk review and in-country mission, covering the various modules/domains for S&T risk analysis and formulation of recommended actions and activities. Most importantly, it included initial candidate recommendations for the S&T Action Plan and input from stakeholders and the Pharos team for ranking these recommended actions. This draft was shared with UNAIDS for initial feedback. The length of this phase was unexpectedly changed by the Covid-19 pandemic that broke out just after Pharos's first mission to Kingston. During this step, the Pharos team also drafted a five-page summary to be used in the Jamaica HIV National Strategic Plan for 2021-25.

S&T Action Plan Virtual Workshop (November 2020): Given the travel limitations imposed by the Covid-19 pandemic, an in-person mission will not be possible during 2020. Instead, the team carried out a virtual workshop. Pharos shared the draft plan with the S&T Committee and other stakeholders in advance of the workshop, where participants were asked to validate the findings and recommendations in the S&T Strategy and Action Plan and to provide inputs to develop a detailed roadmap with milestones for implementation during 2020-24. Afterwards, Pharos conducted phone interviews to gather additional feedback.

Final S&T Action Plan (November-December 2020): The Pharos team finalized the *S&T Plan* presented

here in this report, considering all feedback received and ensuring its alignment with the Government, CSOs, and international partners policies and programs. The S&T Plan will need to be endorsed, aligned with the new HIV National Strategic Plan (NSP), and incorporated in upcoming budgets and funding proposals, including the next grant request by the Country Coordinating Mechanism (CCM) to the Fund.

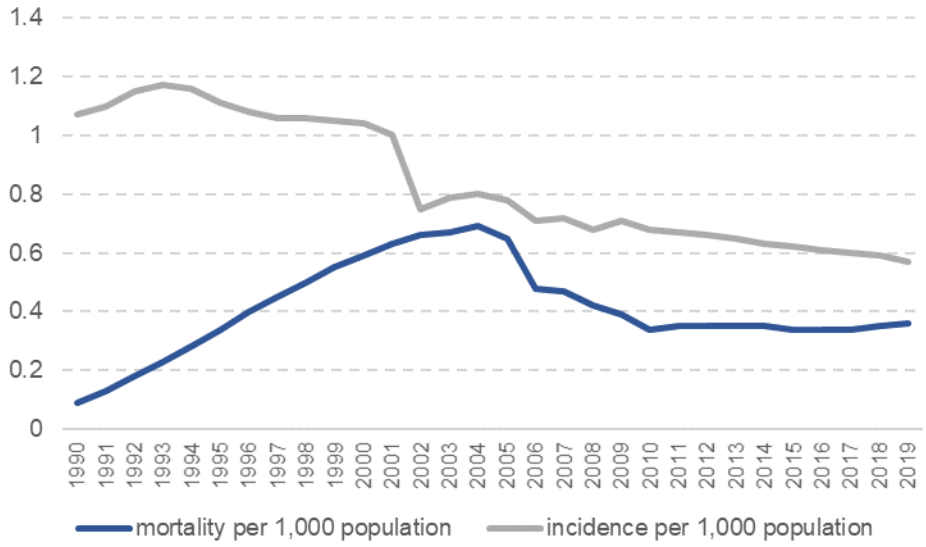
2. Diagnosis of Jamaica's HIV Situation and Response

2.1 Context

2.1.1 Epidemiological Background

In 2018, there were an estimated 32,617 PLHIV in Jamaica. The incidence rate was 0.83 per 1,000 persons and HIV prevalence was 1.5%, down from 1.8% in 2017. Of the 1,165 new cases reported to the MOHW in 2018, 53% were males. Since the first case of HIV was reported in Jamaica in 1982, a total of 37,820 cases (52% males, 48% females) have been notified to the MOHW and 10,485 deaths (60% males, 40% females) have occurred as of December 2018). Most cases have been reported in the 20-59 age group and most deaths have occurred in the 30-59 age group. At the end of December 2019, almost 16% of PLHIV (5,300 persons) were unaware of their status.

Figure 2. Incidence and Mortality Reported in Jamaica by Year and Sex



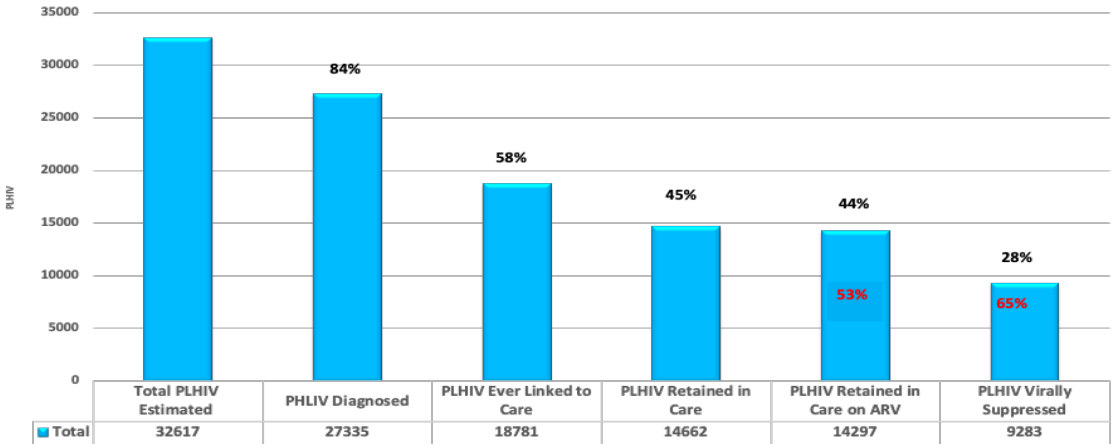
Source: AIDSinfo 2020.

The epidemic is concentrated among key populations, including TGW with a prevalence rate of 51.0%, MSM at 29.6%, homeless persons with 13.8%, inmates at 6.9% and FSW at 2.0%. Most PLHIV are concentrated in urban areas, with the prevalence highest amongst the parishes of St James, Kingston and St. Andrew, and lowest in the parish of St Elizabeth. In light of the concentration of new and prevalent

infections among KPs, there is a strong justification for the government to focus its prevention and treatment efforts among these groups.

Jamaica's current progress on the UNAIDS 90-90-90 targets stands at the following: 84% of PLHIV know their status, 53% of those are on treatment, and 65% of those are virally suppressed. [35] While Jamaica may not achieve the 90-90-90 targets by 2020, progress has been made, especially on the number of PLHIV diagnosed with a remaining gap of only 2,020 patients to achieve the first 90. This reflects the substantial effort that Jamaica has made on testing persons and persons of high risk. If the 90-90-90 goals are to be reached, future investments must focus on services for key populations.

Figure 3. National Treatment Cascade as of January 2020



Source: MOHW Strategic Information Unit.

Table 1. Progress on the HIV Treatment Cascade

Indicator	Objective 2020	Progress	Gap
1st 90	29,335	27,335	2,000
2nd 90	26,401	14,297	12,104
3rd 90	23,761	9,283	14,478

Source: Authors with information from January 2020 National Cascade

[35] Jamaica National Treatment Cascade January 2020

2.1.2 Program Response to Date

Prevention. The National Family Planning Board (NFPB) has lead responsibility for HIV prevention in Jamaica. They procure condoms and lubricants and distribute them for free in collaboration with CSOs. Even so, shortages of these commodities are reported for key populations[36]. Jamaica is also implementing a project for Pre-Exposure Prophylaxis (PrEP) with assistance from the Global Fund. Educational efforts to explain HIV risks and prevention measures are ongoing to combat lack of knowledge among the general population, especially young adults (the 2017 Knowledge Attitudes Perception and Behavioral Survey (KAPB) showed that there was a 4-7 percentage points decrease of knowledge of preventive practices and misconceptions for both males and females among ages 15-24 years compared to 2012). [37] The NFPB has recently been reincorporated within the MOHW after being made a separate and autonomous body for several years. This should facilitate stronger integration of the prevention, treatment, and other components of the national HIV response.

Almost 90% of the Government's prevention budget for 2019 was allocated to key populations. Jamaica's combination prevention programs for KPs, particularly MSM and TGW, depend heavily on outside funding with minimal domestic financial support. Including all prevention activities including for the general population, PEPFAR and Global Fund together covered 39% of prevention-related spending in 2017 with the GoJ accounting for 31% and the remaining 30% by the private sector[38].

Testing and Counseling. While the MOHW treatment cascade data shows that diagnosis of PLHIV is high, there are still issues with finding and diagnosing the remaining 16% of the HIV positive population. Since the early 2000s Jamaica has implemented a contact investigation model, where trained public health care professionals from the MOHW support HIV/STIs prevention.[39] Jamaica's case index (CI) training is a robust year long process, however retention of contact investigators is low.[40] Index testing has been adopted within Jamaica, but CSOs highlight that[41] many persons who identify as MSM and TGW feel uncomfortable discussing sexual partner history for fear of stigma, which limits contact investigators from effectively penetrating the social networks of these populations. These investigators have helped with testing and contact tracing for COVID-19 in 2020.

The 876 Study notes that most MSM (95.0%) and TGW (97.1%) have tested for HIV at least once in their lifetimes, yet only 50.5% of MSM reported testing in the recommended 6-month increments.[42] Providing

[36] Programmatic Review of Prevention Services and HIV Testing Modalities in Jamaica Draft V 2, Local Fund Agent
[37] MOHW (2017). HIV/AIDS Knowledge Attitudes Perception and Behavioral Survey Jamaica 2017
[38] National AIDS Spending Assessment 2015-2017
[39] Dorrett Norrine (2015). STI/HIV Intervention Approached in Jamaica
[40] Western Hemisphere COP 2020 Planning Letter
[41] Validated by JN+ interview
[42] The 876 Study: Integrated Biological and Behavioral Surveillance Survey with Population Size Estimation Among Men who have Sex with Men and Transgender Persons in Jamaica, Ministry of Health Jamaica.

patients with an alternative and confidential way to test for HIV such as self-testing kits needs to be supported by the MOHW, as kits are currently only found in private high-cost pharmacies[43].

Treatment. As shown in the treatment cascade, of all persons diagnosed with HIV, only 58% are linked to care. To address this gap, Jamaica must intensify its efforts to develop new strategies to immediately initiate and keep people in treatment. Evidence shows that not all healthcare workers follow the standard protocol for linking persons to care, such as calling and sending multiple SMS to patients to confirm their appointments.[44] As echoed in the 2020-2025 National Strategic HIV Plan, and campaigns such as the recent return to care campaign, targeted strategies for linkage-to-care need to be reinforced in the coming years.[45] Any proposed solutions will need to consider ways to mitigate stigma and discrimination, a major barrier to linkage to care.

Adherence. Patient lack of adherence is a pervasive issue within the Jamaican HIV program, yet remains not fully understood. The 2020-2025 NSP calls for studies on the profile of persons lost to follow-up (LTFU). Various steps have been taken to decrease LTFU including expanding clinic hours, increasing access to care across different clinics, and establishing various protocols for healthcare workers to raise patient contact.

Low quality of care is another factor causing loss to follow up in treatment and lower rates of viral suppression. Quality is deficient mainly because of weak and inconsistent patient support services by care providers. Protocols to retain patients in treatment are up to date and consistent with global guidelines, but these are not systematically applied in practice, due to inadequate training and refresher courses, weak supervision, and lack of incentives and accountability. A new initiative by the private sector under a USAID-backed project may help to address this issue of quality of care.

Another issue affecting adherence to ART is the lack of timely lab results, which make it difficult to know if patients are taking their medications regularly and achieving viral suppression. The National Public Health Laboratory (NPHL), responsible for viral load (VL) testing in Jamaica and regional reference laboratory for the Caribbean, has not been able to handle the level of VL testing for all PLHIV currently retained in care. Long wait times occur between testing and receiving results, which affects timely antiretroviral (ARV) dosing responses for new and non-suppressed patients as well as timely counseling. Due to COVID-19, the NPHL temporarily stopped processing HIV VL samples, aggravating the already dire situation.

For virally stable and adherent patients, MOHW is considering longer term prescriptions, i.e. a 6-12-month supply, to reduce the burden on laboratory testing. But the efforts to expand testing and diagnosis and the return to care campaign are expected to increase numbers of ART patients, which will put further

[43] Programmatic Review of Prevention Services and HIV Testing Modalities in Jamaica Draft V 2, Local Fund Agent
[44] National HIV Strategic Plan February 2020
[45] National HIV Strategic Plan February 2020

pressure on laboratory capacity. The new 2020-2025 NSP sets a goal to increase VL testing by 30,000 tests annually, and to allow for decentralization of VL testing to the Western and South Eastern Regional Health Authorities (RHAs). The PEPFAR-funded "U equals U" project supports this initiative in promoting treatment literacy for early initiation and adherence to reach VL suppression.

2.2 Sustainable Systems for Health

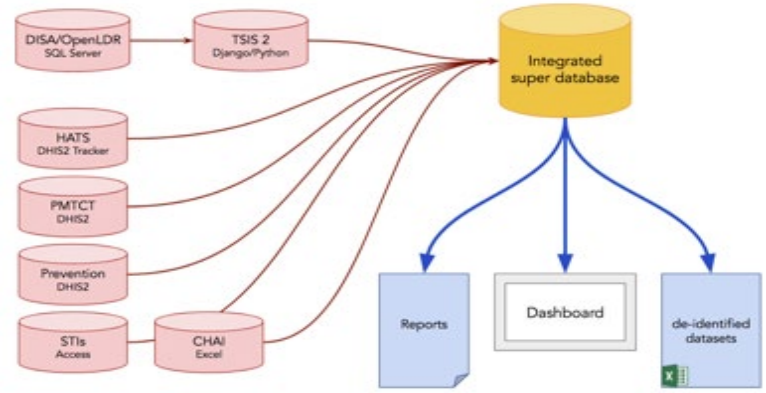
2.2.1 Information Systems

The national HIV Surveillance System has evolved from a paper-based reporting and management system at all levels to a web-based computerized system at the national level that should promote efficient management and analyses of the data. While the surveillance system does not have unique patient identification codes, it does offer KP group classification. However, numerous challenges remain. One of the most serious ones is the fact that data from HIV lab work (testing and diagnosis of HIV positive cases) and VL testing for those on ART are bifurcated and shared with different parts of the Ministry, making overall management of patients more complicated. Information regarding HIV diagnosis is monitored by the Surveillance Unit within the MOHW, while information regarding treatment and viral suppression is maintained by the HIV Unit. In separating these entities to keep medical data protected, managing care provided to individuals and analyzing trends (such as why patients are LTFU) has proven difficult.

To address the challenges identified, the HIV program has focused on linking systems such as the laboratory and pharmacy databases, producing dashboards, developing a system for tracking patients enrolled in the private sector and improving patient confidentiality and privacy. This has included concerted efforts by the MOHW with assistance from the United States Agency for International Development (USAID) to connect the different data systems into a single "Super Database". This "Super Dataset" includes the DHIS2 tracker (case notification data), the Treatment Services Information System (TSIS), the laboratory information system used by the NPHL (DISA), the DHIS2 Prevention of mother-to-child transmission (PMTCT) and Prevention modules and data from STIs (See Figure 4). Overall, this dataset aims to link the four main four data areas: 1) Surveillance (managed by the National Surveillance Unit), 2) Prevention and Outreach (managed by the NFPB), 3) National Treatment (MOHW), and 4) the Repository (contact tracing).

As of February 2020, the Super Database is linked to the National Health Fund Pharmacy Database. In 2019-2020 the National Health Fund (NHF) began rolling out pharmaceutical management software to all public treatment sites, which is believed to increase the accuracy and timeliness of sub-national ARV management reports to the MOHW to improve the forecasting process. Additionally, technical assistance is being provided by PAHO via a quantification tool which helps the MOHW plan its future procurement through a steering committee's annual quantification exercises.

Figure 4. Databases, platforms and dataflow for the National HIV Programme "Super Database"



Source: Revised Integrated Monitoring and Evaluation Plan, HIV (2019-2025).
Note. The different tanks in red symbolize the different databases that are part of the Super Database.

The national HIV monitoring and evaluation (M&E) system periodically undergoes an assessment using the UNAIDS 12 components monitoring & evaluation system strengthening tool.[46] The most recent assessment was conducted in 2018. The challenges to M&E identified were similar to those of the National Health Information System (NHIS), such as: lack of human resources and capacity to conduct surveillance and effectively utilize data, poor data quality and management and weak integration of databases.

As mentioned above, the HIV Unit is currently receiving support from the University of California San Francisco (USCF), as an implementing partner of PEPFAR/CDC, to make the information systems more interoperable and user-friendly. Presently the MOHW is outsourcing the application development for the Treatment database (TSIS). However, the HIV Unit expressed that the in-house staff, who will maintain the system once developed, could do these tasks if provided with the necessary training.

The COVID-19 outbreak has also raised issues of accessibility and data security. This issue will have to be explored in the near future to better respond to current and future unexpected shocks to the health system.

2.2.2 Procurement and Supply Chain

In previous years, the high price of ARVS and frequent stock-outs (1-2 times annually) represented a sustainability risk for Jamaica's HIV response. Given the commitment by the MOHW to ensure that PLHIV have access to medication, several changes have been made to the national procurement and supply management system since 2015, which resulted in zero stock-outs in 2018.[47] The National Health Fund

[46] UNAIDS (2009). These guidelines support the use of the standardized tool: 12 Components Monitoring and Evaluation System Strengthening Tool.
[47] Absorption of ARV Medication Note (Global Fund)

(NHF) rolled out a pharmaceutical management software to all public treatment sites during 2018-2019, which is aimed at increasing the accuracy and timeliness of sub-national ARV management reports to the MOHW to improve the forecasting process.[48] Additionally, technical assistance is being provided by PAHO to help the MOHW plan its future procurement[49] through annual quantification exercises. The price of HIV commodities is now low relative to other Caribbean countries, as the MOHW's purchases of said commodities continue to flow through a national mechanism managed by the NHF and independent of PAHO's Strategic Fund – a technical cooperation mechanism for pooled procurement of essential medicines and strategic health supplies accessible for Latin American and Caribbean Countries.[50] Throughout 2020 due to the global COVID-19 pandemic, the MOHW reported delays in receiving ARV shipments, which they said inhibited expansion of multi-month dispensing. They also noted insufficient storage space at individual pharmacies and proposed increasing the frequency of ARV deliveries to help mitigate the space issue.

Despite the aforementioned improvements, it will be important to continue monitoring gains in the efficiency of HIV commodity procurement and supply chain, as ARVs and related commodities account for a large share of HIV program spending.

2.2.3 Human Resources

In Human Resources (HR), the MOHW agreed starting in 2016 to begin covering HIV-related HR costs previously supported with GF and PEPFAR grants were supposed to be covered with an additional budget of J$500,000 per year.[51] Since then, the government has increased its share of the salaries of all government HIV healthcare workers from 35.9% in 2016 to 42.8% in 2018 (see Table 2). And since 2019, the GoJ has absorbed 46 positions from the GF and 64 from PEPFAR/USAID at a total cost of J$340,488,356. One of the factors that might have facilitated transferring personnel from donor to government budgets is the alignment in public sector and donor-funded salary and benefit budgeting. At the same time, the donors continue to finance about a third of the nearly 700 positions associated with the HIV program, and there is no legal assurance that the government will assume these salary obligations.

[48] Ibid
[49] Stakeholder interviews (Pharos, 2020)
[50] Ibid
[51] Transition Preparedness Assessment – Jamaica.

Table 2. Share of HIV healthcare workers' salaries by funding source, 2014-2019

Funding source	Fiscal Years					Total
	2014/2015	2015/2016	2016/2017	2017/2018	2018/2019	
	J$	J$	J$	J$	J$	J$
GF Grant	374,626,212	362,425,770	542,248,286	640,583,839	571,297,934	2,491,182,040
PEPFAR/USAID Grant	223,665,695	134,048,211	327,362,980	413,452,699	484,054,797	1,582,584,383
Subtotal (GF + PEPFAR)	**598,291,907**	**496,473,981**	**869,611,266**	**1,054,036,538**	**1,055,352,731**	**4,073,766,423**
% (GF + PEPFAR)	**66.9%**	**56.0%**	**64.1%**	**58.0%**	**57.2%**	**59.9%**
GoJ	296,521,910	389,332,580	485,993,820	763,729,012	790,387,626	2,725,964,949
Subtotal (GoJ)	**296,521,910**	**389,332,580**	**485,993,820**	**763,729,012**	**790,387,626**	**2,725,964,949**
% (GoJ)	**33.1%**	**44.0%**	**35.9%**	**42.0%**	**42.8%**	**40.1%**
Total (GF +PEPFAR+ GoJ)	**894,813,817**	**885,806,561**	**1,355,605,086**	**1,817,765,550**	**1,845,740,357**	**6,799,731,372**

A review of GF grant spending shows that 33% of their total 2019-2021 grant resources ($3,992,001 USD) are still allocated to HRH, including both technical and administrative positions for the PR (MOHW) and the SRs (JASL, Children First and ASHE). For instance, the GF is still providing salary support for peer educators, project managers/M&E officers, and a few positions in the MOHW to support the human rights interventions. It also appears that USAID is still funding a small number of senior posts in the HIV Unit related to Strategic Information.

There is a limited availability of human resources in the health sector generally. A 2014 Human Resource Analysis for HIV services revealed that HR levels were only 62% of optimal levels. While all parishes have a shortfall of supporting staff this is particularly an issue in more rural areas.[52] The analysis also showed that health workers focusing on HIV alone have not kept pace with the increase in patient load.[53] Exacerbating the shortage of human resources is the fact that the median age of healthcare workers (HCW) is increasing and there are not enough new recruits to fill the positions of those retiring. Also, like in other Caribbean nations, attrition amongst health care workers (HCW) because of migration to North America and Europe is high.

HIV service training is highly dependent on donor-supported programs. In addition, while the medical schools in Jamaica offer training in HIV/AIDS clinical management, pre-service training for non-medical staff (e.g., social workers, peer-to-peer mentors, case managers) does not cover HIV. Many of these support positions are trained through CSO with assistance from the donor-funded I-TECH[54] Project. PEPFAR/USAID are directly funding the staffing and training of health information officers and covering the salaries of several case investigators employed by CSOs [55]

[52] Interview Dr. Robb-Allen.
[53] Global Fund Standard Concept Note, March 2014
[54] Mentioned in interview, need to confirm
[55] ROP

2.3 Organization, Human Rights, and Governance

2.3.1 Organizational Framework of the HIV Response

The national HIV program of Jamaica is led by the MOHW, specifically by the HIV/STI/TB unit (HIV Unit) and the NFPB. These two sister level departments, along with a separate surveillance program, are the primary bodies responsible for coordinating the governmental response. The new NSP 2020-2025 envisages changes to the governance structure for HIV that includes centralizing the management and coordination of the HIV program under a new and expanded HIV/STI/TB Unit.

The MOHW performs a steering function by developing policy, standards and regulations, monitoring and evaluation, and proposing relevant legislation to parliament. The HIV unit within the MOHW oversees treatment at various clinical sites as well as the monitoring of the treatment and adherence portion of the cascade. The NFPB oversees the prevention arm of the response which include procurement promotion and distribution of free condom and lubricants, as well as conducting research on knowledge of HIV and training of peer navigators.[56]

In 1998, Jamaica's healthcare system was decentralized to four Regional Health Authorities (RHAs). RHAs are autonomous and governed by their own boards. A service level agreement governs its relationship with the central Ministry. While they collect services fees, they also receive resources from the central MOHW. They are charged with delivering HIV services to the population in all 14 parishes at specific treatment sites.[57] The MOHW coordinates with the four RHA, which have directly responsibility implementation of prevention, treatment and strategic information services. Despite being a decentralized system, the National Public Health Laboratory is the sole site for viral load testing. Current efforts are underway to create a decentralized laboratory system by providing viral load testing at specific RHAs.

2.3.2 Human Rights Legal Environment

Jamaica is committed to the promotion and protection of human rights through its agreement to a majority of the *Office of the United Nations High Commissioner for Human Rights'* core human rights instruments[58] and has worked to ensure non-discrimination of PLHIV through the National HIV and Workplace Policies. Despite these efforts, the current legal environment does not enable the national response to operate effectively. Several laws - such as the *Age of Majority Act*, the *Offenses Against the Person Act, Sexual Offenses Act*, and the *Dangerous Drug Act* - inhibit the program's ability to reach marginalized groups driving the epidemic. Legal barriers to HIV testing, prevention, and treatment not only increase the risk of individual transmission, but also heighten the probability of KPs spreading the

[56] Global Fund Jamaica Concept Note

[57] Preliminary findings from the Focalized Evaluation (Slide deck shared by APMG)

[58] https://jis.gov.jm/govt-committed-to-protecting-human-rights/

infection to sexual partners and the general population. For these reasons, the legal environment was seen as a risk to program sustainability in the face of declines to donor funding. The stakeholder interviews reported that the GoJ has not signaled its political will to alter this environment in the short term. For instance, the development of an SRH & HIV policy to address service barriers for adolescents and women and the intensification of HIV awareness and sensitization public campaigns, has been developed but has not been published due to the lack of final approval by the MOHW.

During the final consultations with the national steering committee, members cited the importance of continuing to try to create a more conducive societal and legal environment for vulnerable populations. The Global Fund is allocating $900,000 USD in catalytic matching funds for reducing barriers to access HIV services during 2021-2024.

2.3.3 Governance

Currently the CCM coordinates the HIV response in a multisectoral approach which includes multiple stakeholders such as government ministries, NGOs and the private sector. Before the creation of the CCM, this was overseen by the National Aids Committee (NAC).[59] The NAC was set up more than 15 years ago to coordinate the overall response but has not been functional in recent years. Efforts to relaunch and reform the NAC under the leadership of the Permanent Secretary of Health are under discussion as part of the finalization of the NSP.

The CCM is the sole body that brings together government and civil society representatives. While it currently lacks formal legal standing and its existence is heavily linked to the GF's involvement in Jamaica, the CCM is in the process of reform, to be finalized in early 2021. Proposed changes should help improve sustainability and strengthen continued representation from KP communities following transition from donor funding. If the NAC is revitalized, the representation of CSOs would need to be guaranteed as well as representation from other key sectors such as Finance, Education and Labor and the private sector.

As the NAC is revitalized in the coming months, it will be important to articulate and observe a separation of functions and responsibilities with the CCM. Overall coordination can revert to the NAC, where it will have long-run sustainability regardless of the size and status of Global Fund assistance to Jamaica. The same is true for monitoring the implementation of the Sustainability and Transition Plan, with the TWG as a subcommittee of the NAC. The CCM can then focus on providing a forum for designing and implementing the Global Fund grants to the country, including grant-financed activities to help implement the S&T Plan.

One additional emerging governance matter that Jamaica will have to address in the upcoming years relates to the implementation and monitoring of this S&T Action Plan. To do this Jamaica has formed an S&T Committee with members of the MOHW, MoF, PIOJ, UNAIDS, PAHO and the NGOs and private sector.

[59] National Strategic Plan for HIV.

For a complete list of members see Annex 1. The terms of reference for this group may need to be modified to ensure that it continues with monitoring, and that agreed actions have a clearly designated group accountable for results (for example, it appears that NFPB will be responsible for implementation the social contracting pilot). Other S&T recommendations might have to be assigned to other bodies (e.g., full integration of HIV information systems by the HIV Unit in MOHW, increased funding for KP prevention by the PS's office and Ministry of Finance, etc.)

2.4 Community engagement

2.4.1 Civil society landscape and role in the HIV response

Civil society organizations in Jamaica have worked on HIV for more than three decades. Over 15 CSOs participate in the HIV response, with a strong presence in Kingston. CSOs in Jamaica provide services for a wide range of Key Populations: youth, MSM (including sofa-surfing youth), transgender persons, sex workers, migrants, inmates, PLHIV, homeless persons, drug users, women and girls, orphans and vulnerable children (OVC). Seven types of services are currently provided by these organizations: (1) treatment and care; (2) program coordination and management; (3) prevention; (4) advocacy; (5) social protection; (6) research; and (7) OVC education.[60] Treatment and care includes patient initiation on ART (e.g. JASL prescribes treatment to their clients and is waiting for approval to open a pharmacy) and social protection includes the work between HIV CSOs other Ministries providing housing, support to access education, and financial support for widowers and people living with disabilities. As illustrated in Table 3, the majority of CSOs offer program coordination, prevention and advocacy services. Only JASL, the largest CSO in Jamaica, provides all type of services. It is estimated that CSOs deliver more than 20 percent of HIV-related services in Jamaica.[61] In 2017 JASL provided treatment and care for 5% of PLHIV in the country, through its sites located in Kingston, St. Ann's Bay and Montego Bay.

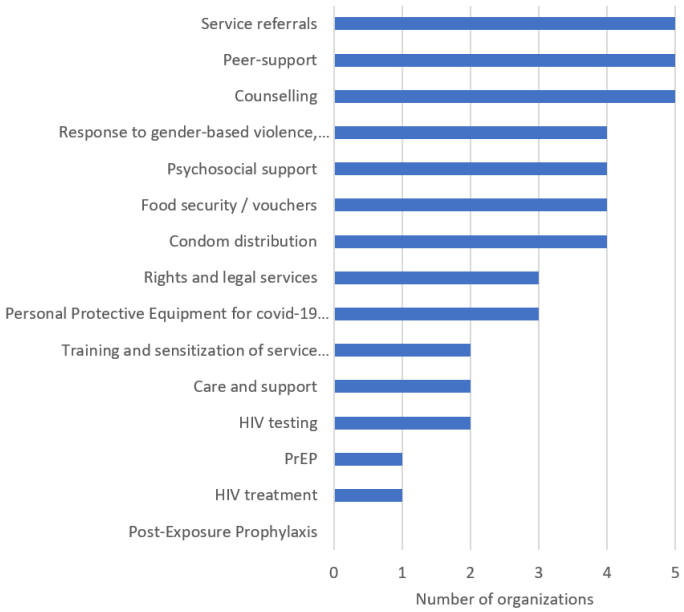
Table 3. Key services provided by CSOs

Organization	Treatment/ Care	Program Coordination	Prevention	Advocacy	Social Protection	Research	OVC Education
ASHE	X	X	X				
Children First	X	X	X				
CVC		X		X		X	
EFL	X	X	X	X	X		X
JASL	X	X	X	X	X	X	X
JCW		X	X	X			
JFJ				X	X		
JFLAG				X		X	
JN+	X	X	X	X	X	X	

[60] Jamaica Civil Society forum on HIV and AIDS (2020). Resource Mobilization Strategy 2020-2024.
[61] Myrie, T. 2019. Legal and Regulatory Assessment for Government funding of civil society organizations to deliver HIV services in Jamaica. Washington, DC: Palladium, Health Policy Plus.

A mapping done by UNAIDS, provide more details of the specific activities carried by five of the largest CSOs working in HIV on JAMAICA (JASL, JN+, JCW, Transwave and ASHE Company).

Figure 5. Specific services delivered by CSOs



Source: UNAIDS, 2020.

Civil society organizations actively participate in the HIV response as part of the technical working groups developing and revising national and international reports including the NSP 2020-2025 and the Global Fund requests. Civil society is also well represented in the CCM with 40% of the seats, and they occupy approximately 25% of the membership of the main Technical Working Groups (TWG) that guide the various components of the HIV national response including the HIV M&E Reference Group (MERG), the Enabling Environment and Human Rights, Prevention and the Treatment and Care TWGs. [62] However, during our mission some organizations criticized the lack of inclusiveness for lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) leaders, for example by not including the transgender people (TRANS) in the Prevention TWG. The Jamaica Civil Society Coalition on HIV is a caucus of non-government players operating in the response and includes 40 members[63]

[62] PIOJ (2017). Transition Preparedness Assessment.
[63] H. Gayle (2017). UWI lecturer urges ethical guidelines in civil society advocacy. Retrieved from http://www.jamaicaobserver.com/news/uwi-lecturer-urges-ethical-guidelines-in-civil-society-advocacy

2.4.2 Civil Society financial performance

According to the latest NASA 2015-2017, the largest sources of funding for CSOs working on HIV in Jamaica continue to be the Global Fund and the US Government. While these CSOs have also received public support from the Jamaican government in the form of in-kind "subventions", these ad hoc arrangements represent a minimal fraction of civil society's income and have not been regularized or linked to a stable funding source. The CSOs thus remain heavily dependent on donors for their financial lifeblood. For instance, through the Global Fund grant, funding for social protection and services, typically provided by the Ministry of Labour and Social Security, is channeled through the MOHW. Last June, a new request of expressions of interest for the provision of HIV services by CSOs was issued by the MOHW in the Sunday Gleaner (See Annex 2). If successful, this pilot could eventually become a new and important relevant source of funding and an example for the region.

Table 4. Civil Society funding by source

Funding source	2015/2016		2016/2017	
	USD	Percentage	USD	Percentage
GoJ	$281,133	6%		0%
USG	$2,238,278	49%	$1,815,576	50%
GF	$1,188,310	26%	$1,116,086	31%
UN	$121,625	3%	$89,178	2%
Other	$784,438	17%	$618,808	17%
Total	**$4,613,785**	**100%**	**$3,639,647**	**100%**

Source: NASA 2015-2017

In the current GF grant, three organizations are listed as subrecipients (ASHE, Children First and JASL), four as sub-subrecipients (JN+, EFAF, Transwave and Jamaicans for Justice), and five as implementing partners (Eve for Life, JCW, Larry Chang Center, RISE life Management Services, and Hope Worldwide). For 2018, the three SR organizations received a budget from the GF of $1.4 million USD.[64] Recently PEPFAR funds are being channeled directly to civil society organizations through an agreement with JASL including additional special funds related to COVID-19. These resources are used by JASL and also channeled from JASL to ASHE, Children First and JN+. Using additional PEPFAR funding from HRSA, JASL also receives technical assistance from ITECH especially for viral load suppression.

The GoJ provides subventions to CSOs in the form of testing supplies, access to training, donated floor space/accommodations, a percentage of the utility bill and human resources.[65] For example, the Jamaican Network of Seropositives (JN+) has had offices located at an MOHW nursing training facility for over 18 years. One good example of collaboration is a contract between the Ministry of Education and EFL to carry

[64] MOHW (2018). Program Continuation Request
[65] TPA, SID 2019, and interviews.

out a school-based HIV prevention campaign. To the extent of our knowledge, there are no current contracts or memorandum of understanding (MoU) agreements between the government and the largest NGOs working in HIV.

CSOs receive technical assistance from UN agencies including UNAIDS, UNICEF, UNDP and the UNWomen. Transwave received support from UNAIDS to organize its Transgender Health and Wellness Conference and a comprehensive TRANS Strategy is underdevelopment with the support from UNFPA and UNAIDS. Another example is Eve for Life who has received support from UNICEF over the past eight years to implement in the program Mentor Moms for women and girls, some of whom are living with HIV/AIDS.[66][67]

Technical Assistance is also provided through PEPFAR/USAID funded capacity building projects such as Health Policy Project (HPP) and Health Policy Plus (HP+) implemented by Palladium International and LINKAGES, and EpiC implemented by FHI 360. JASL enhanced their social media platforms and built demand for their comprehensive prevention, care, and treatment services among KPs via the LINKAGES project and JN+ strengthened their work addressing HIV discrimination reporting and redress over several years working with HPP and then HP+. In addition, PEPFAR/HRSA, through its implementing partner ITECH, provides technical assistance to JASL primarily on viral suppression of its ART patients.

During the interviews CSOs also mentioned they receive grants from other regional organizations and foundations such as CVC, AHF, Johnson & Johnson, European Union, MAC-AIDS, the Robert Carr Fund, Austria Foundation, Give out, OSF Healthcare, Stonewall, and International Transport Worker's Federation (ITF). These alternative sources are especially relevant for those organizations with a strong advocacy focus such as JCW and those working with LGBTQI population such as Transwave. These alternative sources amount to 17% of CSOs income but are not stable, do not cover most overhead expenses and are usually focused on specific activities. It was also mentioned that applying for these resources consumes up to 30% of CSOs' time.

CSOs have also created income generation sources. For example, ASHE uses the income they generate through their art performances to pay for travel expenses or refreshment during HIV events. JASL is in the process of launching a pharmacy in their Kingston facility as a side business and to restart candle making. Other organizations as EFL and Transwave have enabled their portals to receive online donations.

There is a clearly high dependency of CSOs human resources on donor spending. One organization mentioned that donors (GF/USAID) paid for 30 staff positions including M&E, peer navigators and administrative/finance officers.

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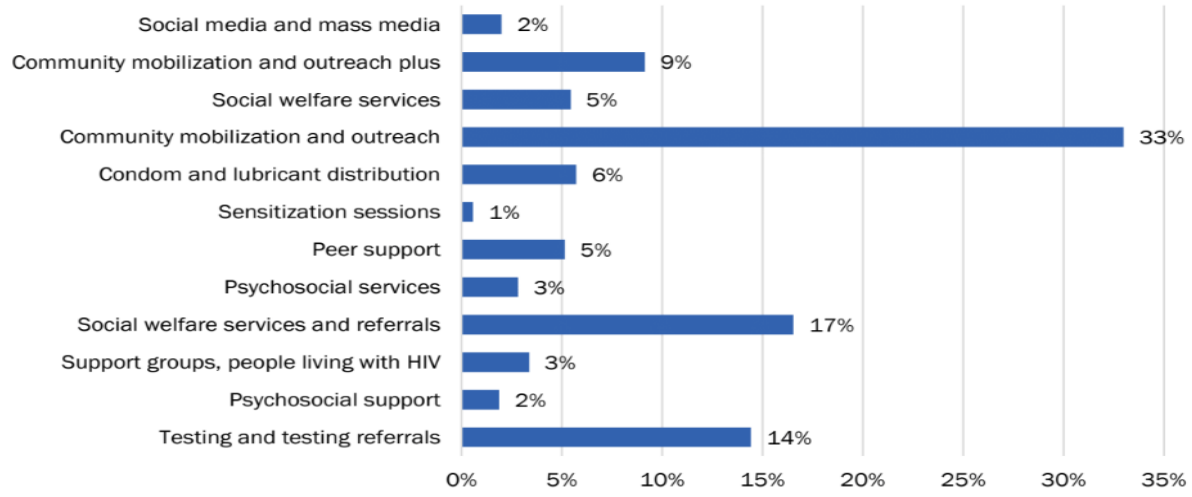
[66] Notes from the mission and https://www.unaids.org/en/resources/presscentre/featurestories/2019/november/20191112_power-transgender-visibility-jamaica

[67] Notes from the mission and https://blogs.unicef.org/jamaica/eve-life-marks-11-years-empowering-survivors-sexual-violence/

The most recent NASA (2018) indicates that CSOs spend one third of their resources on community mobilization and outreach and another third in social welfare and testing services (Figure 6). CSO resources are targeted toward services for MSM and FSW as well as linking them to appropriate care (42% and 17% respectively).[68]

Figure 6. Breakdown of CSO spending by Service Category



Source: NASA 2015-2017

The 2016-17 NASA reports that CSOs account for 21% of total HIV spending in Jamaica. Prevention absorbs 35% of all CSO expenditure, followed by treatment/care (17%) and advocacy (13%) (Table 5 below).

[68] Saint-Firmin, P.P., C. McFarlane, R. Johnson, S. Sutherland, and R. MacInnis. 2020. Understanding the Costs of CSO-Delivered HIV Prevention and Support Services in Jamaica: Policy Implications for Social Contracting. Washington, DC: Palladium, Health Policy Plus.

Table 5. CSO Services by AIDS Spending Category [2016/2017]

AIDS Spending Category	USD	Percentage
Prevention	$1,288,964	35%
Treatment/Care	$643,264	17%
OVC	$6,445	0%
PCPM	$1,181,144	32%
Training	$32,417	1%
Social Protection	$94	0%
Advocacy	$490,052	13%
Research	$44,234	1%
Total	**$3,686,615**	**100%**

Source: NASA 2015-2017
Note: Orphans and Vulnerable Children (OVC), Program Coordination, Planning & Management (PCPM).

2.4.3 Strengths and weaknesses of civil society organizations

In 2019, civil society carried out a SWOT analysis of their own organizations. The study found that CSOs need to improve their capacity for pooled resource mobilization, data collection and performance/financial reporting, income generation, and effective marketing of specific products/services.

Major Strength – The value that CSOs bring to the national HIV response is recognized by the MOHW and their opinions and issues are included in programming.	**Major Weakness** - Heavy dependency on variable external funds makes CSOs highly vulnerable to forces beyond their control.
Major Opportunity - Formalize CSOs and government partnerships through the signature of an MOU and/or public financing models such as social contracting.	**Major Threat -** Outbreak of communicable diseases like COVID-19 can divert resources and attention from HIV/AIDS. Smaller, highly dependent CSOs could lose staff or cease to exist.

Source: Authors based on Jamaica Civil Society forum on HIV and AIDS (2020). Resource Mobilization Strategy 2020-2024.

One step towards civil society strengthening was the creation of the Jamaica Civil Society forum for HIV about a decade ago. This forum has aimed to enhance coordination by creating a space to discuss the sustainability of CSOs and has hosted key planning exercises such as CSO service costing and a Resource Mobilization Strategy 2020-2024. The forum is an attempt to integrate and provide more voice to smaller CSOs and CBOs that are sometimes marginalized. While the civil society recognized this as a major success during our interviews this mechanism was also reported as not functional and challenging by other stakeholders.

Additional capacity gaps mentioned during our interviews were in the areas of accounting, financial management, advocacy literacy (i.e., communication strategies to present their needs and arguments to government officials), and advocacy strategies for resource mobilization. Moreover, an evident

opportunity area is to strengthen the collaboration between CSOs and the RHAs. Confidentiality arises as a recurrent obstacle, but as reported during our interviews, one of the issues is the perception by CSOs (raised by the CSOs several times in interviews) that regional health staff see CSOs as a competitor and a threat, and thus are reluctant to see government funding flow to the CSOs.

2.4.4 Jamaica's progress on social contracting

Historically, the GoJ and CSOs in Jamaica work harmoniously together. CSOs operate in a conducive environment where no laws or policies restrict civil society participation in oversight and service delivery. Throughout the years public funds have been transferred to CSOs by the MOHW and other Ministries such as the Ministry of Education and the Ministry of Labor and Social Security though grants, subventions, or MDAs such as the Social Development Commission. However, these public funds tend to be ad hoc and fall loosely under that Ministry's wider mandate, or they are subjective and lack a transparent formal mechanism that ties into the Ministry's strategic plan.

Only recently the MOHW has shown willingness to formalize a social contracting mechanism for HIV to provide CSOs with financial sustainability after donor funds decrease. Moving in that direction is urgent since CSOs play a unique role in the response that the MOHW or the private sector will not be able to fully fulfill.

After the 2017 TPA was completed, three key technical exercises on social contracting were carried out by Palladium as part of the HP+ project: 1) a legal regulation assessment using the social contracting diagnostic tool from APMG, 2) a costing exercise, and 3) advocacy messages developed for social contracting. JASL, with the support of the Global Fund, also carried out a parallel costing exercise. The studies concluded that the GoJ depends on CSOs' provision of services to key populations to achieve its strategic objectives within the national HIV strategy.

These assessments have prepared the ground for social contracting. The legal assessment proved that there are no legal barriers for CSOs registration and provision of HIV services among key populations. The costing exercises

Priority takeway from the Jamaica CSO Costing Analysis

(Understanding the Costs of CSO-Delivered HIV Prevention and Support Services in Jamaica, HP+, Feb 2020)

- Some key populations are more expensive to reach than others. The cost to deliver a package of services to people living with HIV, transgender persons, and homeless drug users is estimated at fifteen, three, and four times higher, respectfully, compared to the other populations served.
- Staff direct costs are the predominant cost driver of most services provided by CSOs.
- Differences in staffing composition can play a significant part in costs.
- CSOs with high fixed costs can reduce their unit costs when operating at a high-volume.
- Key cost information related to prevention and treatment, care, and support services is now available to be used for social contracting.

provided important inputs that can be used to determine the unit cost of certain HIV services and the total volume of payments under Social Contracts where CSOs are compensated for delivering a defined quantity of services. However, since the cost data collected by HP+ and JASL was self-reported by the CSOs, these data should be independently verified and benchmarked before being used as an official reference. The model should prioritize essential CSO-led key population interventions in prevention, treatment and care and supporting an enabling environment, with special focus on prevention where most CSOs operate.

In Jamaica CSOs can be registered under two different bodies of legislation: (1) the Companies Act and the Friendly Societies Act, (2) or as a charitable organization under the Charities Act.[69] In the Legal and Regulatory Assessment it was suggested that CSOs might have to change their legal status to Foundations or Charitable Societies to be able to enter into official contracts with the GoJ. However, as verified during Pharos's first mission, this does not represent a barrier since most of the organizations working in HIV are already registered under the Charities Act.

As a Global Fund principal recipient contracting with CSO sub-recipients and as a past partner in a Government-to-Government Agreement with PEPFAR/USAID (concluded in 2019), the MOHW's HIV Unit has accumulated major relevant experience channeling donor funds to civil society organizations and RHAs. In implementing Social Contracting, the Jamaican MOHW can draw on this experience in selecting CSOs as sub-recipients and sub-sub-recipients, channeling GF money to these sub-recipient CSOs, and monitoring their performance.

During the past several GF grant-cycles, sub-recipients (SRs) and sub sub-recipients (SSRs) have been selected with an indicative set of activities based on proposals submitted. The PR chooses these SRs from the original list of CSO entities shortlisted, based on their geographic spread/reach, foci and capacity. According to Global Fund policies and procedures, the CCM plays an oversight role in this process.

In 2019, following PEPFAR/USAID funded Health Policy Plus' work analyzing social contracting, the MOHW agreed to explore a pilot mechanism focusing on aspects of the HIV response that CSOs could best address. The intention of this one-year pilot was to have the initial contracts issued during the new fiscal year, April 2020. However, even when the COVID-19 outbreak in March derailed those plans, the request for expressions of interest was published in the Sunday Gleaner on June 21st. This pilot is expected to be launched in the second half of the year and would be subject to the procurement regulations in the Public Procurement Act. If proven successful, a multi-year contracting would likely be explored in the future.

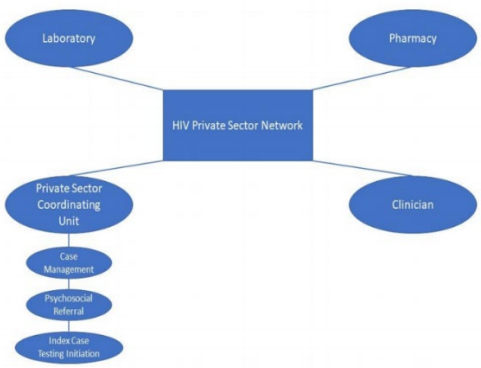
[69] Myrie, T. 2019. Legal and Regulatory Assessment for Government funding of civil society organizations to deliver HIV services in Jamaica. Washington, DC: Palladium, Health Policy Plus.

2.5 Private Sector engagement

With the support of the University of West Indies (UWI), Jamaica is implementing a PEPFAR-funded project via Family Health International (FHI360) to expand access to HIV prevention, treatment, and care through the engagement of private health sector. The motivation of this project, Health Connect Jamaica (HCJ), is to provide an alternative solution to the limited physical and human resource capacity of the public sector to test and treat the additional PLHIV needed to close the treatment gap. The project aims to increase quality as well as quantity of services. Ultimately the investments made through this project and its implementation at a national scale are expected to contribute to the achievement of the 95-95-95 goals by 2030.[70]

The HCJ model is composed of a network of patients and providers, including primary health care services in the private sector, clinicians, laboratories and pharmacies. They help to collecting and enter information in the MOHW's prevention and treatment databases, information that was not previously reported by the private sector. It is estimated that the private sector could reach 25% of PLHIV. The network is coordinated, monitored, and managed by an independent multi-disciplinary Steering Committee chaired by the Permanent Secretary of the MOHW.

Figure 7. Key Components of the HIV Private Sector Network



Source: The HIV Private Sector in Jamaica (2019).

The model is patient-marketing centered and includes education, screening, psychological support, contact investigation and case-management components. The target population comprises newly diagnosed, never linked (never exposed to ART), and lost-to-follow up patients. Model innovations include the use of social marketing and online appointments to increase access to care. During visits, blood is drawn at the POC sites and sent to the centralized lab, which is electronically linked to private provider sites. ARVs are distributed through the pharmacies.

[70] The HIV Private Sector Network in Jamaica. A proposal for the model: structure and functions (August, 2019)

The private sector initiative will also include piloting PrEP and HIV self-testing as new prevention methods. Implementing PrEP has been challenging due to the need of specialty procurement of certain items and its final cost is still uncertain. Self-testing has been planned to be distributed through pharmacies and STI clinics, but further steps are still needed for its full implementation. Nevertheless, focused groups discussions point to high uptake and referral levels.

In terms of financing, HCJ introduced a pre-pay model with differentiated financial contributions associated with payment capacity. The model proposes a reimbursement package through the NHIP for those patients referred by the HIV/STIs/TB Unit and private health insurance reimbursement (80% upfront and 20% on target reached). The model also includes performance-based payments for providers (for instance, by reaching VL suppression targets). Lastly, HCJ is proposing a Discrete Clinical Services PPP model, mainly designed to cover capital costs, maintain facilities and equipment and management and delivery of clinical services. This PPP would need to be proven before MOHW absorption.

In July 2020, this project was officially endorsed by the UWI and MOHW and moved to the roll-out phase after a pilot in the metropolitan areas of Kingston and St. Andrew in 2019/2020. By December 2020, the project had presence in three health regions (South East, South West and the Western) and preliminary results show that the project was able to enroll 230 clients and achieve 88% linkage to care and 90% viral load suppression.

The project will also require clinicians to be accredited by the Medical Council of Jamaica and will provide extensive training on a wide range of topics related to service delivery, including training sessions in stigma and discrimination and gender-based violence.[71]

This intervention complements the efforts from the MOHW and the CSOs. In fact, HCJ has forged relationships with CSOs providing channels for their populations to access the network receive almost free care. Moreover, the private sector model also refers patients to UWI, CHARES and JASL for psychosocial support and Index Case Testing and to the HIV/STI/TB Unit for contact investigation. In terms of its sustainability, this intervention is expected to be fully rolled-out by the MOHW and given its affordability (~ JMD 30,000 ($210 USD) per virally suppressed patient) it could be potentially funded by a future the NHI scheme.

2.6 Financing of the HIV Response in transition

2.6.1 Overall Economic Trends and HIV Expenditures

Jamaica's economy experienced a recovery in recent years. Primary surpluses have continued to increase and the GoJ is coming out of a loan agreement with the IMF while public debt fell from historically unprecedented levels to below 100 percent of GDP in 2018–2019. The unemployment rate in October

[71] HCJ Performance Update. Steering Committee Presentation of Achievements (October 2020)

2018 was 8.7 percent, a reduction of 1.8 percentage points relative to 10.5 percent in October 2017, and almost half the rate at the start of the economic reform program in 2013[72].

While in early 2020 these positive economic developments signaled an increase in domestic investment for the HIV response, they will need to be revised in the light of the recent COVID-19 pandemic and the consequent national and global economic slowdown. One of major impacts in Jamaica's economy is expected to be on the tourism industry, which consists of the main source of taxation and provides close to one-fourth of jobs in the country. Jamaica has been prompt in responding to this crisis with a comprehensive package of tax and economic stimulus measures that include a reduction in the General Consumption Tax from 16.5 to 15% (J$14 billion) and grants for small businesses, the tourism industry and housing sector.[73] Jamaica also requested emergency financing from the IMF for $520 M USD. The Jamaican economy is expected to contract by 8.6% this fiscal year, and to grow 3.6% in 2021.[74]

Regarding HIV financing, the MOHW increased its recurrent budgetary allocations for the GoJ's HIV/AIDS control program from $403.5m JMD in FY18[75] to an estimated $864.6m JMD in FY20, [76] and expanded its capital investments during this period (see tables below). Please note that the MoF considers all donor funding for AIDS as capital expenditure, even though this spending might cover mainly recurrent spending. HIV budgeting information is reported in Jamaica's budget through three main budget lines: "Support to the National HIV/AIDS Response" (where co-financing from the GF is reported), "Reduced HIV Prevalence in Most-at-Risk Population" (where co-financing from PEPFAR/USAID is reported) and "HIV/AIDS Control Services/Technical Services." The budget does not include a specific budget line for HIV prevention.

[72] Myrie, T.2019.*Legal and Regulatory Assessment for Government Funding of Civil Society Organizations to Deliver HIV Services in Jamaica*. Washington, DC: Palladium, Health Policy Plus

[73] KPMG (2020). Jamaica. Government and institution measures in response to COVID-19. Retrieved from: https://home.kpmg/xx/en/home/insights/2020/04/jamaica-government-and-institution-measures-in-response-to-covid.html

[74] IMF (2020). World Economic Outlook, October 2020.

[75] 2019-2020 Recurrent Jamaica Budget (program #10928)

[76] 2020-2021 Recurrent Jamaica Budget (program #10928)

Table 6. Capital and Recurrent Expenditure for HIV/AIDS 2017-2021

Capital Expenditure (Thousand JMD)					
Support to the National HIV/AIDS Response (co-financed with GF)	Year	17-18[a]	18-19[a]	19-20[b]	20-21[b]
	Public	$304,507	$169,536	$221,043	$305,236
	Global Fund	$680,000	$583,276	$544,819	$479,093
	Total	$984,507	$752,812	$765,862	$784,329
Reduced HIV Prevalence in Most-at-Risk Population (co-financed by PEPFAR/USAID)	Year	17-18[a]	18-19[a]	19-20[b]	20-21[b]
	Public	$157,620	$133,000	$136,481*	n/a
	PEPFAR/ USAID	$419,882	$527,437	$385,000*	n/a
	Total	$577,502	$660,437	$521,481[77]	n/a
Recurrent Expenditure (Thousand JMD)					
HIV/AIDS Control Services	Total	$403,535	$869,197	$864,595	$1,100,000[78]
Technical Services[79]	Total	-	-	-	$3,137,284

a- actual spending; b-budgeted amount

*estimated. This information comes from the budgeted amount for public spending (in the 2019-20 budget) as well as the total amount spent during that year (2020-21 budget). Subtracting the latter by the former gives us an estimate of how much USAID spent before cutting funding in late 2019

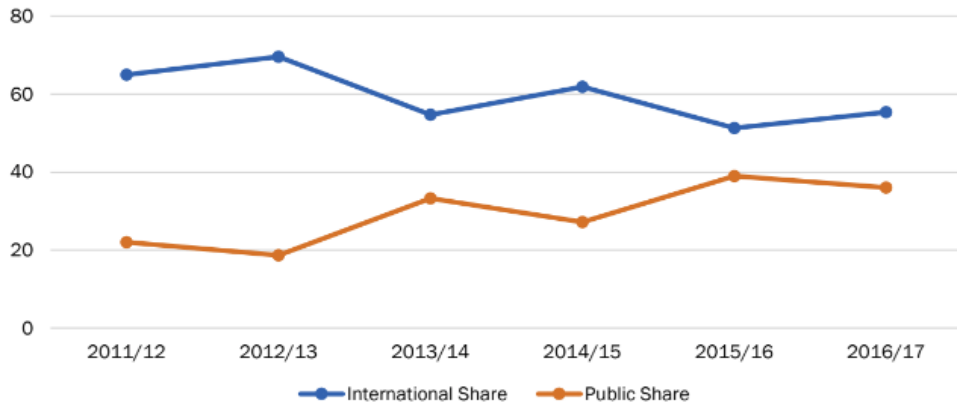
Despite these increases in public financing of the HIV program, the majority of the response has historically been financed externally (see table below).

[77] USAID cut funding to the program in September, 2019 resulting in a lower than estimated amount

[78] From MoF Internal email (Renelle Aarons-Morgan).

[79] HIV/AIDS Control Services were consolidated into Technical Support Services in 2020-2021

Figure 8. International versus public financing share trends in Jamaica's HIV response, percentage



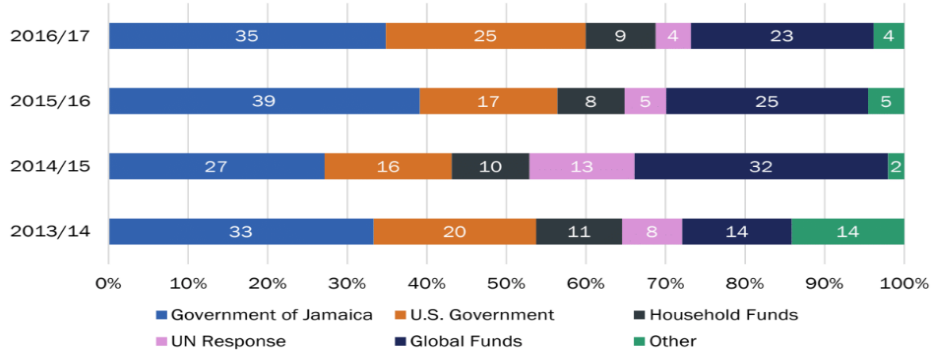
Source: Understanding the Costs of CSO-Delivered HIV Prevention and Support Services in Jamaica: Policy Implications for Social Contracting (2020)

The US Government (PEPFAR) and the Global Fund are the main sources of external financing for the national response, accounting for roughly 48% of total spending in 2017 while the GoJ share was 35.2%.[80] Government outlays, at around $7M USD a year, amount to around 1.2% of overall public spending for health. Over the past few years PEPFAR's allocation for Jamaica has risen and is expected to exceed $9.1M USD in 2020-21. This continued reliance on PEPFAR and the Fund represents a serious sustainability and transition risk, since outside funding is uncertain and the annual projected funding needs for Jamaica's HIV response are expected to increase by $10.7M USD between 2015 and 2020, from $31.3M USD to $42M USD[81] as treatment and other services expand their coverage to reach targets.

Taking into account the expected growth in GDP as projected by the IMF, even if the government assumed the entire cost of the expanded HIV response at $42M USD, this would not exceed 5% of all public expenditures for the health sector. While not an unmanageable amount, such a domestic financing burden might nevertheless strain the country, at a time when it is also dealing with a rapidly growing burden of non-communicable diseases.

[80] National AIDS Spending Assessment 2015-2017
[81] Global Fund Concept Note (JAM-H_ModTemplate_0_en.pdf)

Figure 9. Historical proportion of HIV spending in Jamaica by source (2013-2017)



Source: National AIDS Spending Assessment (2018), from HP+ Report on social contracting.

2.6.2 Future Funding Prospects.

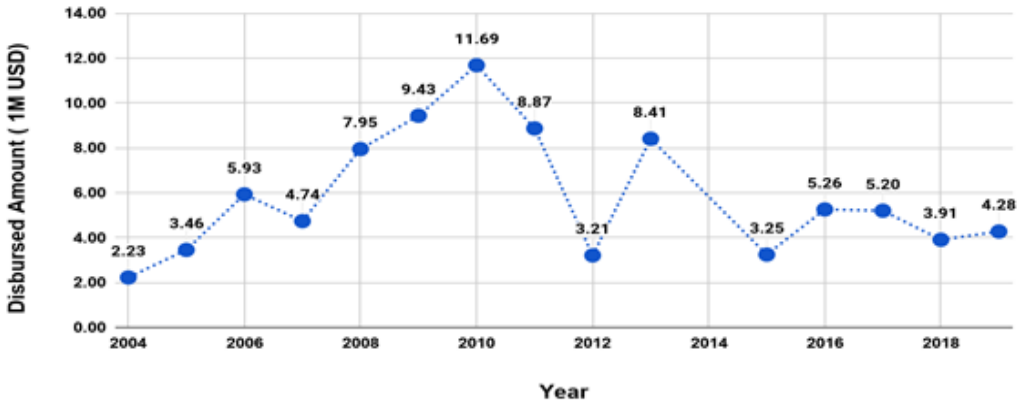
While Jamaica will likely continue to receive donor assistance in the near future, such assistance is beginning to show signs of decline. According to the Global Fund's Data Explorer, which provides grant financial information at the country level, the GF gradually reduced its disbursements to the Jamaica national response between 2013 and 2021. Three-year averages point to a significant decline in three-year averages starting during the 2013-2016 periods and continuing during 2017-19 (note: no data was available for 2014 and was thus excluded from the analysis) [82] Note that absorption has not been a problem for previous and the current GF grant. For 2022-2024, the allocation amount is $11.5 million USD, plus access to catalytic funding if Jamaica meets the requirements for scaling up KP programs and human rights reducing barriers to access to services – for a potential total amount of $13.4 million USD.

GF Financing Trends for Jamaica's HIV program		
3-year average (1M USD)	Year	% Change
3.87	2004 -2006	
7.37	2007 - 2009	90.4
7.92	2010 - 2012	7.5
5.64	2013, 2015, 2016	-28.8
4.46	2017 - 2019	-20.9
3.85	2019 - 2021	-0.1
4.46	2022-2024	0.2

Source: Global Fund Data Explorer.

[82] Global Fund Data Explorer. Retrieved Feb. 5 2020

Figure 10. Global Fund Financing of Jamaica's HIV Response



Source: Global Fund Data Explorer (Ret. Feb 6, 2020)

Looking forward these trends are expected to continue. A second implementation phase for the joint MOHW/GF program 'Support to the National HIV/AIDS Response in Jamaica' was extended for the 2019-2021 period by 11.6M USD (6.0M committed by the GF), of which 4.28M USD was disbursed by the GF in 2019[83]. While the GoJ has responded by increasing its budget for the program,[84] it will eventually need to completely take over financing for the program. Based on the Global Fund Board's decision following the 2020-2022 replenishment, Jamaica has been allocated 11.5M USD for HIV and building resilient and sustainable systems for health (RSSH), or an average of 3.8M USD annually, slightly less than recent disbursements.[85] However, Jamaica may receive additional catalytic financing for human rights activities[86] and for scaling up community-led KP programs.[87] These extra funds could buffer any drop in the country's core allocation from the GF.

PEPFAR moved the hub of its Caribbean Regional Program to Kingston in 2017 and shifted the majority of its funding to support the response in Jamaica. Since then, funding levels have remained fairly stable. PEPFAR financing has also shifted towards improving the 2nd and 3rd pillars of the treatment cascade. Planned FY20 investments in Jamaica predominantly focus on care & treatment (43.3%), program management (20.4%), and testing (14.6%),[88] a shift from 2016-2017 when PEPFAR only spent 8.2% on

[83] Ibid
[84] MOHW Capital Budget 2020-2021 p.9
[85] Jamaica 2020-2022 allocation letter
[86] See Global Fund *'Scaling up Programs to Reduce Human Rights-Related Barriers to HIV Services - Jamaica Baseline Assessment*'
[87] Global Fund Allocation Letter: Jamaica 2020-2022
[88] Victoria Interview

treatment/care.[89] PEPFAR informants in Kingston also advised that Jamaica should prepare for an eventual decline in US Government support, while emphasizing no current plans to discontinue bilateral support to Jamaica.[90]

Table 7. Estimates of HIV/AIDS Financing by Major Funder (USD)

Source	FY14	FY15	FY16	FY17	FY18	FY19	FY20*
GoJ[91]	$4.2m	$4.1m	$7.0m	$6.3m	$6.8m	$8.8m	$8.9m
Global Fund[92]	$1.7m	$3.2m	$5.3m	$5.2m	$5.3m	$4.3m	$4.0m
USG[93] (PEPFAR)	$2.6m	$2.4m	$3.1 m	$4.4m	$3.3m	$4.6	$8.0m

* projected

a Note that differences in fiscal years may lead to slight differences in reporting
Source: Authors' elaboration based on several sources

To summarize, despite recent improvements to Jamaica's macroeconomic environment and increased public expenditure for the HIV response, its financial sustainability remains unclear. This is due to a combination of declining and/or uncertain future funding from the Global Fund and PEPFAR and high reliance on donor financing for key programmatic areas including KP prevention (Global Fund) and linkage to care and treatment adherence (PEPFAR).

3. Updating and Aligning the 2020 S&T Plan

3.1 Main Risks in the 2020 S&T Plan

In 2017, the Jamaica government and UNAIDS commissioned Curatio International to conduct a TPA for Jamaica's HIV program. The purpose of the TPA was to identify key impending transition risks and provide corresponding recommendations and proposed activities to mitigate these risks and enhance the sustainability of the national response. In many ways this report is the second step in the TPA process –

[89] National AIDS Spending Assessment table 29
[90] Palladium Report on CSO Financing
[91] FY14-15 (NASA 2013-15); FY16-17 (NASA 2015-17), FY18-20 (2020-21 Jamaica MoF Budget Report)
[92] FY14 (NASA 2013-15); FY15-17, FY19 (Global Fund Data Explorer); F18 Global Fund Performance Letter; FY20 (2020-2021 Jamaica MoF Budget Report)
[93] FY14-15 (NASA 2013-2015); FY16-17 (NASA15-17);

an effort to update, prioritize, and develop a practical roadmap for implementing the most important sustainability and transition recommendations for Jamaica to follow in the next few years.

Figure 3.1 shows that several of the earlier sustainability risks, such as the risk of insufficient government funding for HIV prevention (Risk 7) and the risk that domestic sources of support for CSOs will not materialize to replace external funding for civil society groups working with key populations (Risk 15), still hold in today's climate. Other risks highlighted in 2017 such as insufficient national purchasing power to obtain low prices for ARVs, (Risk 13) have been addressed over the past three years and have thus been dropped. Others such as the existence of discriminatory laws and stigma (Risk 1) are recognized as persisting in Jamaica, but stakeholders felt that this risk would be politically difficult to address in the next few years and thus asked that it be de-prioritized in the development of the S&T Plan. While this remains a risk in 2020, it will not be addressed in the Action Plan.

As a product of Pharos's desk research and interviews with stakeholders in January-February 2020, the list of the top risks to sustainability and transition was narrowed down to just 6 key ones based on their feasibility and impact:

Sustainable Systems for Health

Risk 1. If linkage to care and adherence to ART do not increase and VL is not timely and extensively reported, fewer patients will be on treatment and thus achieve viral suppression, leading to failure to achieve the second and third 90s.

Risk 2. If the MOHW does not develop national capacity to manage an integrated health information system and strategically use the reported information, there is a large risk of losing M&E capacity for key HIV indicators, which will undermine the country's ability to plan and manage its national HIV response effectively and efficiently.

CSO Engagement and Sustainable Community Response

Risk 3. If the GoJ does not create an institutionalized, transparent and financially sustainable mechanism to transfer resources to CSOs (via "Social Contracting"), key activities currently funded by donors are at risk of being halted and disrupted in the face of decreasing external funds (90% financing of CSOs by PEPFAR and Global Fund).

Improved Governance and Enabling Human Rights Environment for Sustainability

Risk 4. If the HIV response does not have a semi-permanent and legally authorized body to lead the HIV response and does not staff, fund, and politically support such as body, Jamaica will not be able to get on an accelerated path to a sustained, efficient and effective HIV program.

Risk 5. If Jamaica continues to fail adequately address Stigma and Discrimination (S&D), PLHIV will continue to face limited access to services, undermining efforts to reach 90-90-90.

Sustainable Financing for the HIV Response

Risk 6. If GoJ funding for HIV prevention (both delivered by CSOs and by the MOHW/public sector) remains insufficient and does not reach the most at-risk populations, total spending in prevention will continue to be heavily reliant on donors, putting at risk the gains made to date and reducing likelihood of achieving the first 90.

Risk 7. It will be challenging for the GoJ to increase its budget allocations for AIDS treatment as the number of persons enrolled in ART rises to reach the 95-95-95 targets. The treatment budget could nearly double in the next five years as the country moves from having 49% of its PLHIV on treatment to the goal of over 90% by 2025.

Risk 8. If other competing diseases start demanding more public resources as part of future National Health Insurance, HIV budget lines could be reduced – unless HIV is seen as part of the NHI benefits package.


SUSTAINABLE GOVERNANCE AND HUMAN RIGHTS
Risk 1. Discriminatory laws reduce HIV treatment, testing uptake, and generally heighten the risk for HIV spread. Additionally, stigma may lead to underrepresentation in surveillance data, making it difficult to properly diagnose the problem and develop adequate interventions.
Risk 2: Integration of NFPB-SHA into a broader national coordinating body may impede management of Jamaica's HIV response. Additionally, the CCM is the only coordinating body between the GoJ and CSOs, but lacks any legal power. Furthermore, CSO capacity to manage programs and fundraise is limited.
Risk 3: Few economic studies have been conducted in Jamaica to serve as practical tools for HIV budget projections. Appropriate monitoring is necessary to adequately inform the GoJ's budgetary commitments.
Risk 4: Effective coordination of HIV response is not legally empowered to ensure strong coordination across sectors.
Risk 5: No transition plan to ensure sustainability of Jamaica's HIV response.
Risk 4. If the HIV response does not have a semi-permanent and legally-authorized body to lead the HIV response and does not staff, fund, and politically support such as body, Jamaica will not be able to get on an accelerated path to a sustained, efficient and effective HIV program
Risk 7. It will be challenging for the GoJ to increase its budget allocations for AIDS treatment as the number of persons enrolled in ART rises to reach the 90-90-90 targets. The treatment budget could nearly double in the next five years as the country moves from having 49% of its PLHIV on treatment to the goal of over 81% by 2025
SUTAINABLE FINANCING
Risk 6: Declared political will has not translated into adequate and stable increases in investment in health care due to fiscal challenges in the country. These challenges include a large debt problem as well as a poor macroeconomic environment.
Risk 7: HIV prevention strategies targeting vulnerable populations have traditionally been financed by external donors with little involvement from the State.
Risk 8. If other competing diseases start demanding more public resources as part of future National Health Insurance, HIV budget lines could be reduced – unless HIV is seen as part of the NHI benefits package.
Risk 6. If GoJ funding for HIV prevention (both delivered by CSOs and by the MoHW/public sector) remains insufficient and does not reach the most at-risk populations, total spending in prevention will continue to be heavily reliant on donors, putting at risk the gains made to date and reducing likelihood of achieving the first 90.
SUSTAINABLE FINANCING
Risk 8. HR costs for the HIV response remain largely dependent on external support. The current staff shortage might grow worse if the GoJ is unable to absorb the costs of human resources currently paid by donors.
Risk 9: IBBS studies have been mainly financed through external funds. Unless adequate national funding is secured, critical epidemiological and program related data may not be available in the future.
Risk 5. If Jamaica continues to fail adequately addressing Stigma and Discrimination (S&D), PLHIV will continue to face limiting access to services undermining efforts to reach 90-90-90.
SUSTAINABLE SYSTEMS FOR HEALTH
Risk 10: A weak HIV information system and full reliance on donors' funds for surveillance studies pose high risks to program sustainability.
Risk 11: Data dissemination and sharing is seen as an area of weakness as data is not reaching civil society to guide programming and/or advocacy efforts
Risk 12: Structural challenges, stigma and discrimination, and weak HIS are limiting the country's ability to track prevention and treatment outcomes.
Risk 2. If the MoHW does not develop national capacity to manage an integrated health information system and strategically use the reported information, there is a large risk of losing M&E capacity for key HIV indicators, which will undermine the country's ability to plan and manage its national HIV response effectively and efficiently.
Risk 13: Weak purchasing power of suppliers for HIV drugs and frequent stock outs despite use of GF procurement and supply chain.
Risk 14: ART coverage remains far below the Fast-Track treatment targets. Linking to treatment and care services, retention, and survival rates need to be improved
Risk 1. If linkage to care and adherence to ART do not increase and VL is not timely and extensively reported, fewer patients will be on treatment and thus achieve viral suppression, leading to failure to achieve the second and third 90s.
SUST. CSO RESPONSE
Risk 15: CSOs in Jamaica, largely dependent on external funding, provide a significant HIV service delivery to marginalized populations (major drivers of epidemic). CSOs expressed concerns that accepting funds from the GoJ may cripple their advocacy/watchdog function.
Risk 3. If the GoJ does not create an institutionalized, transparent and financially sustainable mechanism to transfer resources to CSOs (via "Social Contracting"), key activities currently funded by donors are at risk of being halted and disrupted in the face of decreasing external funds.

3.2 Review of the Recommended Actions for the 2020-24 S&T Plan

The 2017 TPA also contained a large set of recommended actions for Jamaica. A number of these are no longer relevant, either because they have been addressed over the past three years (for example, the recommendations to update information on Key Population sizes and prevalence have been implemented through the 876 Study) or because they were viewed by national stakeholders in 2020 as being of lower importance or not amenable to implementable solutions in the next few years, because of political infeasibility or other factors.

Other new recommendations emerged from the analysis and stakeholder dialogue in 2020. Chapter 4 gives the full list of updated and prioritized recommendations, the criteria for this prioritization, and considerable details on the rationale for the choice of prioritized recommendations for implementation in the 2020-24 Plan.

4. Recommended Solutions to Address the Main S&T Risks

Based on updated information from Jamaica, extensive stakeholder interviews, and careful analysis, several key HIV sustainability and transition risks emerged in early 2020. In some cases, these echoed risks that had been highlighted earlier, including in the 2017 TPA. In other instances, the risks were new or brought out dimensions of S&T that received little or no mention during earlier discussions. These top risks were vetted and endorsed at a stakeholder meeting on 22 February in Kingston, attended by the Permanent Secretary of the Ministry of Health and Wellness and other senior officials (see table below). For each risk, one or several recommended actions are also shown. These have also been discussed with stakeholders but require additional consultations before they are finalized.

In total, eight priority risks are shown in the table, along with 18 main recommended actions for the Government and donors to undertake. In the rest of this chapter, we go through each of the seven risks and point briefly to the evidence that supports the risk analysis. Then for each risk we describe the corresponding recommended action(s) and begin to discuss how the recommendation could be implemented, key early milestones of achievement, who would be the lead agencies involved, and what might be the major obstacles to successful implementation and how to address them. The table below simply highlights the main actions needed to respond to the identified risk, while the Roadmap matrix in Chapter 5 gives greater details. As the government embarks on each area of the Roadmap, e.g., self-testing and PrEP for MSM, expanding viral load testing, operational plans and budgets need to be developed to guide implementation. This is already happening in some areas such as social contracting with CSOs.

Table 8. Summary of the Alignment of Risks and Recommendations in the 2020 S&T Plan

Sustainability and Transition Risks	Recommended Roadmap Actions
E. Sustainable Systems for Health	
Risk 1. If linkage to care and adherence to ART does not increase and VL is not timely and extensively reported, fewer patients will achieve viral suppression, leading to failure to achieve the third 90	1.1 Monitor linkage to care and support extended work of case managers and patient navigators. Use public, NGO, and private sector providers to expand coverage.
	1.2 Raise the throughput capacity of National Public Health Laboratory system by strengthening Regional Laboratories for timely and effective Viral Load testing.
	1.3 Decrease LTFU of ART patients through rapid treatment initiation immediately upon receiving test results and quality adherence counseling by CSO and private providers.
	1.4 Support and monitor the performance of HCJ (private health sector engagement project) and develop a plan for its long-term sustainability beyond donor funding.
	1.5 Document how social support is currently provided to PLHIV and identify opportunities to increase its performance and sustainability
Risk 2. If the MOHW does not develop national capacity to manage an integrated health information system and strategically use the reported information, there is a large risk of losing M&E capacity for key HIV indicators, which will undermine the country's ability to plan and manage its national HIV response effectively and efficiently. Important periodic surveys (IBBS, population size estimates, serosurveys) depend heavily on donor financing and could be threatened by dwindling external funding.	2.1 Ensure that MOHW HIV unit has in-house capacity to manage its strategic information databases, reducing and eliminating donor dependence for key positions and specialized know-how expertise
	2.2 Complete the process of systems alignment for improved interoperability and strengthening of information systems, closing data gaps.
	2.3 Promote use of strategic information for comprehensive just-in-time program and patient-level management
	2.4 Begin the process of sharing the cost of IBBS and other key surveys with government and ensure that

	these are fully budgeted within the next five years
F. CSO Engagement and Sustainable Domestic Support	
Risk 3. If the GoJ does not create an institutionalized, transparent and financially sustainable mechanism to transfer resources to CSOs (via "Social Contracting"), key activities currently funded by donors are at risk of being halted and disrupted in the face of decreasing external funds (90% financing of CSOs by PEPFAR and Global Fund).	3.1 Implement and evaluate a CSO social contracting mechanism pilot led by the MOHW, gradually increasing its funding to replace donor funding for CSOs, reaching 100% domestic financing within the next 3-4 years.
G. Sustainable Governance and Enabling Human Rights Environment for Sustainability	
Risk 4. If the HIV response does not have a semi-permanent and legally-authorized body to lead the HIV response and does not staff, fund, and politically support such as body, Jamaica will not be able to get on an accelerated path to a sustained, efficient and effective HIV program	4.1 Strengthen the coordination of the national HIV response by appointing an appropriately empowered and staffed national AIDS council
	4.2 Appoint and maintain a Sustainability and Transition technical working group/committee to oversee the S&T Plan, once endorsed by the GoJ
Risk 5. If Jamaica continues to fail to adequately address Stigma and Discrimination (S&D), PLHIV will continue to face limited access to services undermining efforts to reach 90-90-90 targets.	5.1 Promote the adoption of an anti-discrimination law
	5.2 Implement a National Human Rights Strategy that includes: (1) a National Human Rights Institute; (2) strengthening the human rights and gender components in the HFLE curriculum; (3) the implementation of a permanent national human rights campaign; and (4) ongoing sensitization trainings for healthcare providers, legal operators, security forces, teachers and parents.
H. Sustainable Financing for the HIV Response	
Risk 6. If GoJ funding for HIV prevention (both delivered by CSOs and by the MOHW/public sector) remains insufficient	6.1 Shift from donor to government financing of social contracts with CSOs using sustainable sources (approx. US$ 4 million a year at present)

and does not reach the most at risk populations (especially MSM), total spending in prevention will continue to be heavily reliant on donors, putting at risk the gains made to date and reducing likelihood of achieving the first 90.	6.2 Increase national financing of HIV prevention services delivered by MOHW/public sector, reduce donor dependency – progressive increase in co-financing to reach 50% by 2022 and 100% by 2026
	6.3 Implement and sustain effective interventions to reach the most at risk MSM population, such as self-testing and PrEP, and explore ways that CSOs can extend their reach to MSM
Risk 7: It will be challenging for the GoJ to increase its budget allocations for AIDS treatment as the number of persons enrolled in ART rises to reach the 90-90-90 targets. The treatment budget could nearly double in the next five years as the country moves from having 49% of its PLHIV on treatment to the goal of over 81% by 2025	7.1 Conduct scenario planning to project future funding needs for treatment, and incorporate these in the MTEF and annual budgets agreed between MoF and MOHW. Simultaneously utilize international competitive procurement to obtain favorable ARV prices
Risk 8. If other competing diseases start demanding more public resources as part of future National Health Insurance, HIV budget lines could be reduced – unless HIV is seen as part of the NHI benefits package.	8.1 Ensure that HIV figures prominently in future National Health Insurance package definition and in NHI financing

4.1 Sustainable Systems for Health

As highlighted in chapter 2, Jamaica has made important strides in recent years to address some weaknesses in the country's health system that could undermine progress in fighting HIV and could be vulnerable to reductions in donor support. Progress has been achieved, for example, in having the government take over the funding of many positions in the Jamaica health service that were previously paid for by PEPFAR and the Global Fund. At the same time, there are still two issues that create significant risks for the sustainability of the national response especially in the face of declining external support.

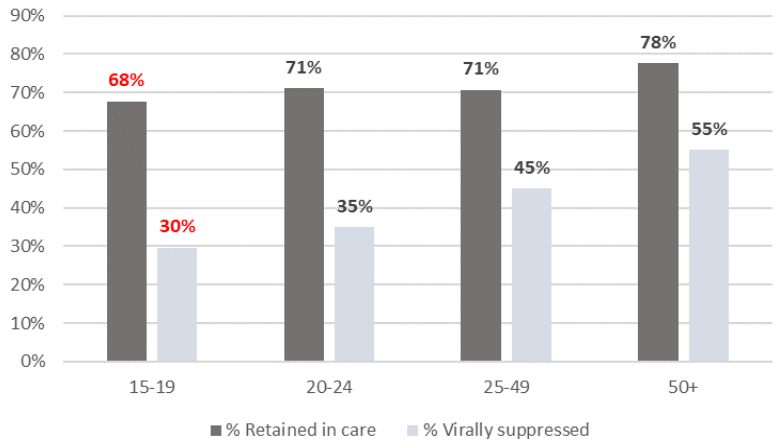
Risk 1. *If linkage to care and adherence to ART does not increase and VL is not timely and extensively reported, fewer patients will achieve viral suppression, leading to failure to achieve the third 90.*

Chapter 2 documented the fact that viral load testing in Jamaica does not have the capacity to monitor ART patients' viral load in a timely way, and this situation will be further exacerbated by the expected rise in the number of PLHIV who are tested and linked to treatment. There are not enough GeneXpert machines to do VL testing, and those currently in place are centralized in Kingston, making it difficult to

collect samples, test them, and return the results to patients and their providers with quick turnaround. The average turnaround time from testing to results is six weeks.

Poor linkage to care and LTFU are still problems in Jamaica with retention in care rates lower than 80%. At the same time, viral load suppression is also remarkably low, especially in younger population (30% for the 15-19 age group). This highlights two of the current programmatic weaknesses that need to be addressed in order to improve the treatment cascade.

Figure 11. Retention in care and VL suppression by age group



Source: MOHW HIV Unit.

Recommendation 1.1. Monitor linkage to care and expand the work of case managers and patient navigators. Use public, NGO, and private sector providers to expand coverage. Case managers and patient navigators need to set higher targets for coverage and rates of linkage and retention, and these need to be more closely monitored by supervisors, with incentives for strong performance. A comprehensive plan involving government, CSO, and private sector providers must be developed and implemented. Having this information available could also be used as an input in setting up the performance goals and rates of payment to CSOs as part of future social contracting.

Recommendation 1.2. Raise the throughput capacity of National Public Health Laboratory system by strengthening Regional Laboratories for timely and effective Viral Load testing. Plans to install GeneXpert machines in the Regional Health Authorities, validate these labs, and begin using the decentralized VL testing system need to be implemented. MOHW is aware of this issue and is receiving help from PEPFAR (through the new Cooperative Agreement with the CDC that has an overall funding of 2 M USD for 2021) to install the new system. Changes in VL testing need to be closely monitored and any bottlenecks that arise must be swiftly resolved. Additional staff, training, and support to data entry and analysis in the HIV patient database may also be required. As highlighted during Pharos first mission, this recommendation should be part of a larger initiative on lab decentralization in Jamaica. To implement this recommendation, the MOHW might develop a roadmap to decentralize VL and other types of tests starting in 2021, as a gateway for building a more comprehensive lab network in the next five years. This

recommendation merits urgent implementation given the additional weaknesses to the laboratory system exposed by the COVID-19 pandemic.

Recommendation 1.3. Decrease LTFU of ART patients through rapid treatment initiation immediately upon receiving test results and quality adherence counseling by CSO and private providers. MOHW efforts to collaborate with laboratories and to target and track those patients with the low-adherence profile (i.e. socially vulnerable, with mental health issues, poor healthcare seeking behaviors, etc.) must be intensified in the short-medium term. Tailored patient recovery interventions need to be designed by region (and by gender, since 55% of LTFU patients are women). Since family and work commitments and long-waiting times to access care in health facilities were reported as two of the most common reasons for defaulting care, innovative approaches should be developed and reinforced such as telemedicine follow-up consults, drug delivery close to work/home, multi-month scripting, "fast-passes" at clinics for certain non-adherent patients, etc. Constant tracking and reporting between sites and the MOHW is critical, and the private sector LTFU database should be integrated with the MOHW data.

Recommendation 1.4. Support and monitor the performance of HCJ (private health sector engagement project) and develop a plan for its long-term sustainability beyond donor funding, assuming that it continues to deliver good results. The MOHW should continue its support for the private sector strategy to maximize its impact on the treatment cascade, increasing coverage and quality. At present the HCJ relies fully on donor funding. A medium-term plan endorsed by the PS as the Chair of the project steering committee would help to clarify the next steps for expanding private sector services and pathways to eventual absorption in the MOHW budget and/or national health insurance.

Recommendation 1.5. Document how social support is currently provided to PLHIV and identify opportunities to increase its performance and sustainability. Possible strategies to be studied including analyzing the feasibility of the MOLSS absorbing the psychosocial support currently provided by the Global Fund (i.e., living support, travel stipends, food vouchers, income generating loans, continuing education, etc.). Ideally this could evolve as a subsidy to those suffering from chronic diseases including HIV. TA could be used to formulate a policy proposal and estimate the budgetary requirements.

***Risk 2**. If the MOHW does not develop national capacity to manage an integrated health information system and strategically use the reported information, there is a significant risk of losing M&E capacity for key HIV indicators, which will undermine the country's ability to plan and manage its national HIV response effectively and efficiently*.

Stakeholders recognize that having an HIV information system that first brings together key information on HIV/AIDS (surveillance, vital registration/death records, patients on ART, VL suppression, coverage and quality of prevention services, etc.) and also links to the rest of the national health information system of Jamaica is vitally important to the achievement of the HIV National Strategic Plan goals and to the long-term integration of HIV with other primary health care services in the country. While there has been progress in this area, the weak connections between HIV surveillance and ART patient tracking continue to hinder the HIV information system, and shortages of personnel and reliance on donors for key positions in the strategic information division of the MOHW HIV Unit pose continued challenges.

Recommendation 2.1. Ensure that MOHW HIV unit has in-house capacity to manage its strategic information databases, reducing donor dependence for key positions and specialized expertise. It is urgent for the MOHW, with support from PEPFAR and the Global Fund, to develop and implement a plan to absorb donor-funded information specialist positions in the MOHW HIV Unit with government budget. It is relevant that these positions, currently funded by UCSF as a CDC implementing partner, are on establishment of the GoJ (rather than contracts) – this will be giving benefits and stability to the post as they are transferred to GoJ budget. This is an opportunity to further develop the in-house capacity in strategic information management and cutting-edge technology in a sustainable way.

Recommendation 2.2. Complete the process of systems alignment for improved interoperability and strengthening of information systems, closing data gaps. Currently the approach Jamaica is following consists of integrating the information from the surveillance and programmatic strategic information at the parish level, with this data feeding into the central level integrated database. The next step in the process is to migrate the prevention and the repository (contract-tracing) information to the same platform that interconnects with the treatment data base, and ultimately with the surveillance dataset. The latter would also need to undergo a cleaning process similar to the one recently done with the HIV mortality registry. To accelerate this process the MOHW might need to support the RHAs with upgrades in equipment and possibly staffing/training. This would be particularly relevant for rural facilities that still lack adequate IT infrastructure.

Recommendation 2.3. Promote use of strategic information for comprehensive just-in-time program and patient-level management. The fragmentation of the HIV databases has negatively impacted the availability of timely information for decision-making. Creating a dashboard with key indicators in prevention, linkage to care, treatment, and viral suppression by region and facility (integrating inputs from the three main existing databases) would become a key tool for the new unified HIV/STI/TB Unit. Ways in which information could be delivered expeditiously and in easily usable form to the facility level to improve patient management still need to be discussed**.** The different parts of the MoHW managing the fragmented pieces of the HIV information system must be required by the Minister and PS to share and combine their data.

4.2 CSO Engagement and Sustained Domestic Support

As mentioned in detail in Chapter 2, CSOs currently play a major role in the HIV response in Jamaica, especially in working with key populations on prevention and treatment adherence and in advocacy and the protection of legal and human rights. They are seen by GoJ as valued partners, yet the financing for their activities come almost entirely from PEPFAR, the Global Fund, and other outside agencies. Over the long run, this is not a sustainable arrangement.

Risk 3*. If the GoJ does not create an institutionalized, transparent and financially sustainable mechanism to transfer resources to CSOs (via "Social Contracting"), key activities currently funded by donors are at risk of being halted and disrupted in the face of decreasing external funds (90% financing of CSOs by PEPFAR and Global Fund at present).*

Overall, the CSOs operate under a conducive environment where no laws or policies restrict civil society participation in health and other social service delivery. While there is precedent for the GoJ to transfer

cash to CSOs under grants or subventions in the areas of Education, Labour and Social Security, and the National Health Fund currently has several contracts with NGOs (e.g., screening services contracts with the Diabetes Association of Jamaica and the Heart Foundation of Jamaica), the MOHW has historically relied on donors to back CSOs in the field of HIV, while providing mainly in-kind contributions in the form of test kits, condoms, some accommodations and transportation, etc. Little has been done to ensure that a formal social contracting mechanism for HIV is established to provide financial sustainability after donor pullouts.

In 2020, the Ministry of Labour and Social Security had Ja$200 million earmarked to support NGOs catering to a wide cross section of key and vulnerable groups ranging from youth, disabled communities and homeless populations. The team under the Social Security arm of the Ministry developed and publish the RFP, which received over 200 proposals. However, due to COVID-19 the selection and contracting processes have stopped, and it is unclear if or when they will continue. Furthermore, it is not clear if this was a true social contracting process since the mechanism was more similar to grants, without clear monitoring or accountability.

Based on international experience[94], a well-designed social contracting mechanism should include:

- Transparency throughout the process (application, selection, and accountability). To guarantee transparency of the selection process a committee integrated by the MOHW, MoF, HIV Program, and agencies such as UNAIDS, PAHO and UNDP needs to be formed.
- Evidence-based decision-making processes. For example, the payments for services should be linked to costing estimates and interventions should be made based on epidemiological studies and best practices.
- Clarity from TB/STI/HIV Unit on aspects of the HIV response that could be more efficiently and effectively outsourced to CSOs already working with target populations, with a proven track record and governance structures.
- Strong leadership from the MOHW with designated staff and administrative processes to manage the mechanism and ensure that its processes are standardized, published and effectively monitored.
- Sustainable and predictable budget for a specific budget line.
- CSOs with adequate skills to develop proposals, monitor and report progress and demonstrate cost-efficiency

In recent years, and following the 2017 TPA, three key technical studies on social contracting were completed with USAID support: 1) a legal-regulatory assessment, 2) a costing exercise, and 3) advocacy message development. In addition, with assistance from the Global Fund carried out an assessment on

[94] Ministerie van Volksgezondheid (2019). Suriname Social Contracting Roadmap: A How-To Guide for Advancing Public Funding to Civil Society Organizations to Deliver Critical HIV Services (TA supported by HP+).

readiness for social contracting and CSO financial resource mobilization. These exercises position Jamaica well to implement social contracting starting in 2021.

Some precedent has been set, as the Ministry of Health has extensive experience contracting CSOs as subrecipients/sub-awardees of previous and current PEPFAR/USAID and GF grants. There are opportunities to modify the known contracting models, while also potentially adopting some of the best contracting practices from the NHF, to address the issue of transparency and determine accurate costs and monitoring indicators. The Public Procurement Act of 2015 and amendments of 2018 provide the needed legal guidance on outsourcing procurement of goods and services by government bodies.

As part of the current Sustainability and Transition Planning effort reported here, stakeholders created a menu of four options for HIV Social Contracting (see matrix below). Option 1 has CSOs obtaining funding from the Ministry of Labor's broader social interventions fund. Option 2 involves a separate HIV social contracting scheme managed by the MOHW with a dedicated budget line, in which MOHW selects CSOs and enters contracts with each one. Under Option 3 MOHW would contract with a single umbrella CSO that would in turn sub-contract with smaller CSOs, much as JASL is currently doing with funding from PEPFAR. In Option 4, the National Health Fund would act as the MOHW's intermediary for social contracting, along the lines of what the NHF currently does for diabetes and heart disease. In all options, the GoJ would take over the contracting of HIV CSOs from PEPFAR and the Global Fund and would pay CSOs based on quantity and quality of service delivered, using clear and transparent norms. The pros and cons of each Option are highlighted in the table. During Pharos first mission the Permanent Secretary and other national stakeholders indicated a preference for model 1.

Table 9. Four alternative models for social contracting in Jamaica

Model Option	Pros	Cons
1.Implement a social contracting pilot led by an MOHW secretariat (with a few dedicated staff)	•Full time attention from MOHW team •Could pool more funds for HIV (including donors) •It can be flexible to adjust to HIV Program needs •Potentially more transparent •HIV Unit staff expertise in managing grants from PEPFAR and GF (with support of the LFA) in house. •Public Procurement Act of 2015 and amendments of 2018 already in place.	•Requires a new unit/staff to be established – would it sunset? •Requires creating new rules and processes • Social contracting demands new NGO monitoring and accountability mechanisms •Requires new allocation from MoF
2. Use the MoLSS social interventions fund to earmark resources for HIV projects delivered by CSOs	•The funding mechanism already exists •No legal barriers for NGOs •Auditor General has the capacity to monitor funding •It can be competitive and flexible to adjust to HIV Program needs •Public Procurement Act of 2015 and amendments of 2018 already in place.	•The model is new and there might be unknown difficulties •MoLSS capacity to monitor HIV programmatic indicators •Crowding out by NGOs or private organizations in other sectors •The allocation might be hard to sustain every year •Limited $ amounts (~J$200 M)
3. Sign MoU between MOHW and an umbrella CSO to manage social contracting, following the experience of other Ministries (e.g. Ministry of National Security –	•The SR/PR mechanism in place and CSOs have the relationship and capacity for monitoring and reporting •Easier for GoJ to keep one organization accountable, MOHW lightens burden by delegating to umbrella organization •Donors are aware of lead NGOs and	•Potential lack of transparency between the umbrella and sub-granting organizations •GoJ has less visibility into the activities of the sub-grantees

Peace Management Initiative)	would be inclined to support development of systems	
4. Replicate/apply the Contracting Agreement model used by NHF for NCD promotion and prevention (e.g., heart and diabetes foundations)	•Arrangement already exists for NCDs •NHF has technical capacity to manage, grants, procure, monitor, etc. •Could help to ensure that HIV promotion and prevention are included in the NHI benefits package	•Would require strong coordination between the MOHW and NHF •Less HIV Unit/MOHW ownership? •Limited understanding of HIV national response and working with key and vulnerable populations of on areas such as gender and sexual diversity •The PS office is not represented in the NHF Board of Management

Recommendation 3.1. Implement and evaluate a CSO social contracting mechanism pilot led by the MOHW, gradually increasing its funding to replace donor funding for CSOs, reaching 100% domestic financing within the next 3-4 years. Whichever of the four options is selected, it is imperative that the social contracting model be country-owned and responsive to the needs of all PLHIV in the Jamaican context. There is no 'silver bullet', as each of these approaches has its pros and cons. The choice of social contracting model should therefore be taken by the GoJ. In that regard, the MOHW Permanent Secretary announced in September 2019 that his ministry would launch a social contracting pilot by April 2020. This was reiterated during the workshop on HIV Sustainability and Transition in Kingston on 21 February 2020.

There is need for additional sensitization of key senior gatekeepers at MOHW, MoF, MoLSS and NGOs to ensure there is clarity on the difference between grants, subventions and social contracting. A critical area that needs to be addressed is agreement on what aspects of the HIV response will be outsourced to CSOs and the standard unit costs against which proposals will be assessed.

Technical assistance to the MOHW may be needed to build a comprehensive business plan for the social contracting pilot – design, implementation, and monitoring. The Ministry of Finance needs to agree to establish a budget line for this purpose, too. Global Fund and PEPFAR should be consulted as well, so that current funding from the donors for CSOs can be dovetailed with the GoJ contribution and a single overarching approach to CSO selection, contracting, payment, and monitoring can be adopted across the HIV program. If donors intend to phase down their funding for CSOs as the GoJ gradually raises its financing, this will need to be carefully coordinated to ensure that CSOs are adequately funded during such a transition period. A tripartite committee (GoJ/PEPFAR/GF) could be useful to plan and avoid any gaps.

The Permanent Secretary of MOHW will oversee the implementation of Social Contracting, calling on the relevant units in the Ministry. It has been announced that the NFPB will play a central role in steering the

piloting and implementation of the social contracting mechanism, with support from the HIV Unit of the Ministry. Together they need to:

- Finalize a strong and feasible Social Contracting Roadmap for operationalizing this mechanism and to inform CSOs of the process
- Conduct all phases of the pilot of Social Contracting including RFP, proposal review and selection, contract award, monitoring and evaluation
- Promote throughout the full engagement of key stakeholders, including government and civil society organizations, key and vulnerable populations, private sector, academia, and donor partners.

4.3 Improved Governance and Enabling Human Rights Environment for Sustainability

As highlighted in Chapter 2, it is vitally important that Jamaica have strong political leadership behind its HIV response. This is especially the case in view of the substantial stigma and discrimination that PHLIV face in the country and the complex, multi-sectoral nature of the national program, which requires synchronized planning and action by several parts of MOHW (HIV Unit, NFPB, Surveillance team, Regional Health Authorities, etc.) Historically there has been a national AIDS council but in recent years it has become moribund. All of these conditions create challenge for effective leadership and governance of the response.

If the NAC is revitalized as proposed by the permanent secretary for health (as the nominal head of the NAC) and included in the NSP, then the roles and responsibilities of the CCM also have to be refined. The CCM can focus more exclusively on the Global Fund grants (design, implementation, monitoring) and step away from overall coordination of the national response, which is the normal ambit of the NAC. The NAC can also provide for strong multi-sectoral representation and for involvement of international partners, and for oversight of the Sustainability and Transition Plan. It will be important for the NAC to give voice to non-governmental stakeholders including CSOs and the private sector, as these actors currently participate in the national response via the CCM, and their views should continue to be welcomed.

***Risk 4**. If the HIV response does not have a semi-permanent and legally authorized body to lead the HIV response and does not staff, fund, and politically support such as body, Jamaica will not be able to get on an accelerated path to a sustained, efficient and effective HIV program*

International experience and best practice suggest that National AIDS Coordinating bodies should promote strong national ownership; resilient, accountable and transparent systems; efficient approaches to monitoring and evaluation of the national AIDS strategic plan; and coordination of external partners and domestic stakeholders including CSOs and the private sector. They must:[95]

[95] https://www.undp-capacitydevelopment-health.org/en/capacities/national-coordinating-bodies/

- Develop a clear vision and structure to develop, monitor and evaluate the national strategy
- Coordinate and represent all the key sectors operating within the country
- Strengthen policies and guidelines to meet the country needs, in line with the national strategy
- Develop quality products and services to respond to the needs of stakeholders and key populations

Recommendation 4.1. Strengthen the coordination of the national HIV response by appointing an appropriately empowered and staffed national AIDS council/committee. The creation of a new National AIDS Coordinating body or the revival of the existing NAC is a specific strategic activity in the draft NSP 2020-2025. However, its composition, roles, and responsibility remain to be determined. It is suggested that roles and responsibilities include multi-sectoral coordination, development and oversight of the NSP, monitoring of the Sustainability and Transition Plan, and integrating the views of public, private, and civil society actors, and ensuring adequate financing of the NSP from donor sources and from domestic resources including the MOHW budget and national health insurance. MOHW should take the lead by expeditiously studying options for the new body and setting it up by the end of 2020, early in the life of the new NSP. To ensure accountability, this coordinating body should be independently evaluated after two years of operation.

Recommendation 4.2. Appoint and maintain a Sustainability and Transition technical working group/committee to oversee the S&T Plan, once endorsed by the GoJ. Best practice from around the world[96] suggests that the National AIDS Coordinating body should appoint a semi-permanent committee to monitor the S&T Plan, which ideally should form a clear section or chapter of the NSP. The S&T committee should be composed of 8-12 persons from the different government, CSO, and donor institutions involved in the HIV response and most directly involved in carrying out the actions in the S&T plan that will enable an effective transfer of financial responsibility to domestic resources.

The TWG should meet regularly, under the chairmanship of the Permanent Secretary of MOHW, to review progress on sustainability and transition actions. Progress reports should be drafted by a small technical group composed of officers from the HIV/AIDS Unit and the NFPB, who would take the lead in their respective areas (e.g., HIV/AIDS on health systems and financing, NFPF on social contracting)

Risk 5. *If Jamaica continues to fail to adequately address Stigma and Discrimination (S&D), PLHIV will continue to face limited access to services undermining efforts to reach 90-90-90 targets*.

While interventions in the Human Rights arena were graded by the Sustainability and Transition Committee to have low implementation feasibility because of political and cultural barriers, stigma and discrimination in Jamaica and their negative impact on access to care inhibits progress in moving towards

[96] Pharos Global Health Advisors (2020). Sustainability and Transition Review of global practices. Technical Assistance for the Global Fund.

global and national HIV program goals. Therefore, this risk area deserves re-prioritization to continue past efforts to advocate for legal and other human rights reforms.

Recommendation 5.1. Promote the adoption of an anti-discrimination law. As proposed in the NSP 2020-2025 there is a need for a comprehensive and enforceable anti-discrimination law. This law would provide legal protection of PLHIV across different areas including employment, education, housing, and social support.

Recommendation 5.2. Implement a National Human Rights Strategy that includes: (1) the creation of a National Human Rights Institute; (2) strengthening the human rights and gender components in the HFLE curriculum; (3) execution of a permanent national human right campaign; and (4) ongoing sensitization trainings for healthcare providers, legal operators, security forces, teachers, and parents. Following the example of other countries, Jamaica could put forward a comprehensive National Human Rights Strategy with detailed costs and designated responsibilities across institutions. The Global Fund HIV, Human Rights and Technical Brief proposes seven areas to frame such a strategy: 1) Reduce HIV-related stigma and discrimination; 2) Train health care workers on human rights and ethics related to HIV; 3) Sensitize lawmakers and law enforcement agents; 4) Provide legal literacy ("know your rights"); 5) Provide HIV-related legal services; 6) Monitor and reform laws, regulations, and policies related to HIV; and 7) Reduce discrimination against women and girls in the context of HIV.

4.4 Sustainable Financing for the National HIV Response

Risk 6. *<u>If GoJ funding for HIV prevention</u> (both delivered by CSOs and by the MOHW/public sector) remains insufficient, total spending in prevention will continue to be heavily reliant on donors, putting at risk the important progress achieved to date in working toward the first 90*

The GoJ has made substantial increases in financing for the national response over the last five years - from an annual 240m JMD in 2013/14 to 1.17b JMD in 2018/19 - to cover gaps left behind from declining donor funds while also shifting its focus to the second and third pillars of the treatment cascade. However, as mentioned in Chapter 2, PEPFAR and the Global Fund continue to account for over 90% of all spending on HIV prevention and 80% of the HIV activities of CSOs, with little input from the national budget. While the GoJ appears to have adequate fiscal space to increase its investments in the HIV program, the budget lacks a line dedicated to prevention. Such domestic budget allocations will be required to finance prevention services for the general population and implemented by the National Family Planning Board, as well as to fund an increasing share of the resources used by CSOs in testing and counseling KPs[97], providing combination prevention to them, and assisting KPs who are infected on how to adhere to treatment.

[97] Jamaica HIV Prevention Review

To address this risk, three recommended actions are proposed:

Recommendation 6.1. Shift from donor to government financing of social contracts with CSOs using sustainable sources (approx. US$ 4 million a year at present) To ensure that CSOs are appropriately and sustainably financed as donor funding winds down, the MOHW, with the backing of the Ministry of Finance, should establish and fund a Social Contracting Scheme (see below for more details on the design of the scheme). In the first year, the GoJ might cover 25% of the financing requirements of the CSOs, while PEPFAR and the Global Fund cover most of the needed resources. Each year the national budgetary contribution could then grow by another 25%, until year 4 when domestic funds fully pay for social contracting and the donors can exit this part of the HIV program. This will require coordination and joint monitoring among the main donors and the MOHW. A body to do this will also need to be established at the outset. Such a body can build upon the Ministry's experience in working as a principal recipient of the Global Fund and as a cooperating partner of PEPFAR, in developing the full set of contracting, payment, and performance monitoring skills required (in particular for interventions targeted to KPs).

Recommendation 6.2. Increase national financing of HIV prevention services delivered by MOHW/public sector, reduce donor dependency. Like the recommendation above, the MOHW needs to ensure that HIV prevention services carried out by NFPB have adequate domestic financing. To do so, a prevention budget line needs to be created and funded. A team from MOHW, led by NFPB, should plan and cost these prevention activities during 2021 so that they can be included in the budgets approved for the following fiscal year.

Recommendation 6.3. Implement and sustain effective interventions to reach the most at risk MSM population, such as self-testing and PrEP, and explore ways that CSOs can extend their reach to MSM. Jamaica should continue its efforts to document the cost-effectiveness of pilots targeted to MSM such as PrEP and self-testing. After assessing their cost-effectiveness and implementation feasibility, the MOHW should discuss and plan for their scale up and integration in the national response.

Risk 7. *It will be challenging for the GoJ to increase its budget allocations for AIDS treatment as the number of persons enrolled in ART rises to reach the 90-90-90 targets. The treatment budget could nearly double in the next five years as the country moves from having 49% of its PLHIV on treatment to the goal of over 81% by 2025.*

Recommendation 7.1. Conduct scenario planning to project future funding needs for treatment, and incorporate these in the MTEF and annual budgets agreed between MoF and MOHW. Simultaneously utilize international competitive procurement to obtain favorable ARV prices. The HIV Investment Case currently being led by the STWG with input from international consultants will help to define these medium-term funding needs to successfully expand ART coverage. A range of scenarios should be examined, linked to the country's ability to expand its service delivery capacity and to finance treatment scale up. The estimated funding requirements should be discussed with the Ministry of Finance and included in annual and three-year budgetary frameworks.

Risk 8*. If other competing diseases start demanding more public resources as part of future National Health Insurance, HIV budget lines could be reduced – unless HIV is seen as part of the NHI benefits package*

While the development of National Health Insurance is still at an early stage in Jamaica, it appears that NHI discussions have been mainly focused on non-communicable disease prevention, screening and management, since non-communicable diseases (NCDs) account for a large and growing share of the burden of illness in the country. One of the key functions of the existing National Health Fund, which collects wage taxes from those in formal employment, is to purchase and distribute tests and medicines for NCDs including hypertension, cancer, and diabetes. At the same time, since HIV has been historically financed by donors as a vertical program, and in recent years by earmarked allocations in the MOHW budget. HIV prevention, testing and AIDS treatment are widely viewed as being outside of the boundaries of NHI (except for HIV screening which was included in the Green Paper on NHI)[98]. Thus, there is a distinct risk that HIV prevention, diagnosis and care will not be counted as part of the NHI benefits package and will not be eligible for financing from a future NHI Fund. While we do not anticipate that the MOHW will halt funding for testing and treatment, having these activities as well as prevention included in the NHI would have major positive implications for the financial sustainability of the HIV response.

Recommendation 8.1. Ensure that HIV figures prominently in future National Health Insurance package definition and in NHI financing. While it is good that HIV, and especially diagnostic tests and anti-retroviral drugs, are being paid through the MOHW budget, a potentially more sustainable way to finance these commodities and services (currently costing the GoJ USD 5-6 million a year) would be to include HIV screening and care in the NHI package. While NHI does not appear to be on the short-term horizon, it should be seen as a possible medium- term financing solution. To ensure that this happens, representatives from the MOHW HIV Unit, backed by PEPFAR and the Global Fund, should play an active part of in NHI working group discussions, with the endorsement of the Minister and Permanent Secretary. If useful, the MOHW and its donor partners could also commission a consultancy to estimate the expected costs of the HIV benefits package as part of larger NHI actuarial analysis. There are also many ancillary costs associated with HIV prevention and treatment, including care for opportunistic infections, fees for outpatient visits to providers, and additional diagnostic and monitoring tests, which are not fully covered under the “free” (subsidized) services of the health ministry. The full range of such costs should be factored into conversations on the scope and cost of the HIV packages to be covered under NHI.

[98] MOHW (2019). Green Paper on National Health Insurance Plan for Jamaica

5. Roadmap for Implementing the S&T Plan

Objective	Action	Responsible	Possible Funding Source(s)	2021	2022	2023	2024	2025
1. Increase linkage to care and adherence to ART and timely report of VL results	1.1 Monitor linkage to care and support extended work of case managers and patient navigators. Use public, NGO, and private sector providers to expand coverage.	MOHW/RHAs	MOHW GF	X	X	X	X	X
	1,2 Raise the throughput capacity of National Public Health Laboratory system by strengthening Regional Laboratories for timely and effective Viral Load testing.	MOHW (PS Office)	MOHW PEPFAR	X	X	X		
	1.3 Decrease LTFU of ART patients through rapid treatment initiation immediately upon receiving test results and quality adherence counseling by CSO and private providers.	MOHW, HCJ, CSOs	PEPFAR GF	X	X	X	X	X
	1.4 Support and monitor the performance of HCJ (private health sector engagement project) and develop a plan for its long-term sustainability beyond donor funding	MOHW (PS Office)	PEPFAR	X	X			
	1.5 Document how social support is currently provided to PLHIV and identify opportunities to increase its performance and sustainability	MOHW/MOLSS	MOHW GF	X				
2. Develop national capacity to manage an integrated health information system	2.1 Ensure that MOHW HIV unit has in-house capacity to manage its strategic information databases, reducing and eliminating donor dependence for key	MOHW (HIV/STI/TB Unit)	MOHW	X	X	X		

and strategically use the reported information.	positions and specialized know-how expertise							
	2.2 Complete the process of systems alignment for improved interoperability and strengthening of information systems, closing data gaps.	MOHW (HIV/STI/TB Unit)	MOHW	X	X	X		
	2.3 Promote use of strategic information for comprehensive just-in-time program and patient-level management	MOHW (HIV/STI/TB Unit) /RHAs	MOHW	X	X	X	X	X
3. Create an institutionalized, transparent and financially sustainable mechanism to transfer resources to CSOs	3.1 Implement and evaluate a CSO social contracting mechanism pilot led by the MOHW, gradually increasing its funding to replace donor funding for CSOs, reaching 100% domestic financing within the next 3-4 years.	MOHW (PS Office)	MOHW (with support from UNAIDS and GF)	X	X			
4. Re-install and strengthen national bodies to lead the HIV response, and monitor the implementation of this S&T Action Plan	4.1 Strengthen the coordination of the national HIV response by appointing an appropriately empowered and staffed national AIDS council/committee.	MOHW (PS Office)	MOHW	X	X			
	4.2 Appoint and maintain a Sustainability and Transition technical working group/committee to oversee the S&T Plan, once endorsed by the GoJ.	UNAIDS	UNAIDS	X				
5. Address and reduce Stigma and Discrimination (S&D)	5.1 Promote the adoption of an anti-discrimination law.	MOHW (NFPB)	UNAIDs, UNHRC	X	X	X		
	5.2 Implement a National Human Rights Strategy that includes: (1) a National Human Rights Institute; (2) strengthening the human rights and gender components in the	MOHW (NFPB)	MOHW (with support from UNAIDS and GF)	X	X			

	HFLE curriculum; (3) the implementation of permanent national human right campaign; and (4) ongoing sensitization trainings for healthcare providers, legal operators, security forces, teachers, and parents							
6. Increase public funding for HIV prevention to eventually replace donor funding	6.1 Shift from donor to government financing of social contracts with CSOs using sustainable sources (approx. US$ 4 million a year at present)	MOHW (PS Office)/MoF	MOHW	X	X	X	X	X
	6.2 Increase national financing of HIV prevention services delivered by MOHW/public sector, reduce donor dependency.	MOHW (PS Office)/MoF	MOHW	X	X	X	X	X
	6.3 Implement and sustain effective interventions to reach the most at risk MSM population, such as self-testing and PrEP, and explore ways that CSOs can extend their reach to MSM	MOHW (PS Office)	MOHW/PEPFAR/GF	X	X	X		
7. Expand fiscal space to cover the expected increased costs of AIDS treatment to achieve the 90-90-90 targets	7.1 Conduct scenario planning to project future funding needs for treatment, and incorporate these in the MTEF and annual budgets agreed between MoF and MOHW. Simultaneously utilize international competitive procurement to obtain favorable ARV prices	MOHW/MoF	MOHW	X	X			
8. Secure the inclusion of HIV as part of the NHI benefits package	8.1 Ensure that HIV figures prominently in future National Health Insurance package definition and in NHI financing.	MOHW	MOHW	X	X	X		

6. Conclusion

Jamaica has made significant progress in recent years in pursuing its national HIV program response. Prevention and treatment services have expanded considerably. The government has taken over financial responsibility for portions of the program, including paying for treatment services. CSOs and the private sector are playing important roles in reaching key populations. Public officials are committed and capable.

At the same time, the long-term prospects and sustainability of the response are unclear. The level of dependence on outside funding remains high, especially for certain key components of the national program. Reliance on technical assistance is also high in specific areas such as information systems. The partnership between the public sector and NGOs, and between the government and the private sector, still requires greater integration, the use of public funds to pay non-government providers for services, and better legal and administrative frameworks and regulatory capacities.

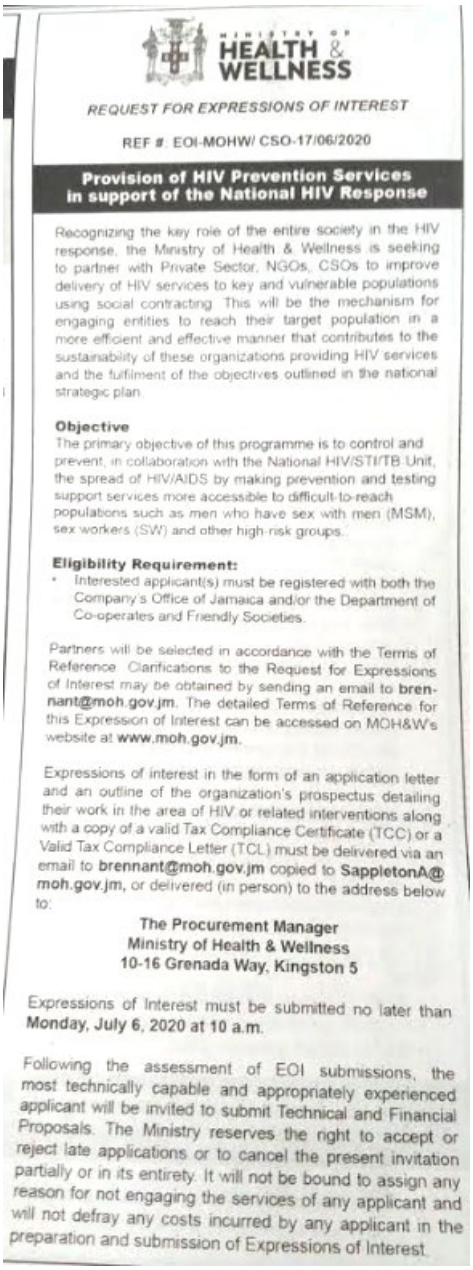
This report summarizes the main sustainability and transition risks facing the HIV program and points to potential solutions and short-term actions that can be taken to improve the national HIV response while building a strong domestic financing base for its continued implementation. The STWG and the revamped National AIDS Council can provide a solid governance framework for leading, implementing, and monitoring the S&T Work Plan spelled out here. Recommended actions should be incorporated in the government budgets, Global Fund grant proposals, and PEPFAR Country Operational Plans, to ensure that they are backed with the needed investments and high-level political support.

7. References and Annexes

Annex 1 Members of the S&T Committee

Name	Organization	Position	Contact Information
Carolyn Gomes	Developing country NGO delegation at the GF Board	*Alternate Board member*	carolyngomes2016@gmail.com
Renelle Aarons-Morgan	Ministry of finance and the public service	*Head of Social Sector projects*	renelle.Aarons-Morgan@mof.gov.jm
Alisha Robb-Allen	HIV/STI/TB Unit, Health Promotion and Protection Branch, MOHW	*Head of Treatment, care and Support*	allenas@moh.gov.jm
Jasper Barnett	Health Systems Improvement Branch, Policy, Planning and development Division, MOHW	*Director (Acting)*	BarnettJ@moh.gov.jm
Valeska Stempliuk	Health Surveillance, Disease Prevention and Control, PAHO/ WHO Office for Jamaica, Bermuda & The Cayman Islands	*Advisor*	stempliv@paho.org
Denese McFarlane	Population and Health Unit, Social Policy, Planning and Research Division, Planning Institute of Jamaica (PIOJ)	*Health Specialist*	dmcfarlane@pioj.gov.jm
Geoffrey Barrow	PreP, Self-testing and Private Sector partnership for HIV treatment	*Lead Consultant*	barrow.geoffrey@gmail.com
Kevin Harvey	AIDS Health Care Foundation	*Caribbean Regional Director*	Kevin.Harvey@aidshealth.org
Manoela Manova	UNAIDS	*Country Director for Jamaica*	ManovaM@unaids.org

Annex 2. Request for Expressions of Interest (social contracting)



MINISTRY OF HEALTH & WELLNESS

REQUEST FOR EXPRESSIONS OF INTEREST

REF #: EOI-MOHW/ CSO-17/06/2020

Provision of HIV Prevention Services in support of the National HIV Response

Recognizing the key role of the entire society in the HIV response, the Ministry of Health & Wellness is seeking to partner with Private Sector, NGOs, CSOs to improve delivery of HIV services to key and vulnerable populations using social contracting. This will be the mechanism for engaging entities to reach their target population in a more efficient and effective manner that contributes to the sustainability of these organizations providing HIV services and the fulfilment of the objectives outlined in the national strategic plan.

Objective

The primary objective of this programme is to control and prevent, in collaboration with the National HIV/STI/TB Unit, the spread of HIV/AIDS by making prevention and testing support services more accessible to difficult-to-reach populations such as men who have sex with men (MSM), sex workers (SW) and other high-risk groups.

Eligibility Requirement:

- Interested applicant(s) must be registered with both the Company's Office of Jamaica and/or the Department of Co-operates and Friendly Societies.

Partners will be selected in accordance with the Terms of Reference. Clarifications to the Request for Expressions of Interest may be obtained by sending an email to **brennant@moh.gov.jm**. The detailed Terms of Reference for this Expression of Interest can be accessed on MOH&W's website at **www.moh.gov.jm**.

Expressions of interest in the form of an application letter and an outline of the organization's prospectus detailing their work in the area of HIV or related interventions along with a copy of a valid Tax Compliance Certificate (TCC) or a Valid Tax Compliance Letter (TCL) must be delivered via an email to **brennant@moh.gov.jm** copied to **SappletonA@moh.gov.jm**, or delivered (in person) to the address below to:

The Procurement Manager
Ministry of Health & Wellness
10-16 Grenada Way, Kingston 5

Expressions of Interest must be submitted no later than **Monday, July 6, 2020 at 10 a.m.**

Following the assessment of EOI submissions, the most technically capable and appropriately experienced applicant will be invited to submit Technical and Financial Proposals. The Ministry reserves the right to accept or reject late applications or to cancel the present invitation partially or in its entirety. It will not be bound to assign any reason for not engaging the services of any applicant and will not defray any costs incurred by any applicant in the preparation and submission of Expressions of Interest.

Annex 3. SWOT Analysis of Jamaican NGOs

Strengths	Weaknesses
• Located close to KPs served and linked to international networks. • Strong collaboration with GOJ & international development partners • Strong national, individual CSO brand recognition • CSOs with track record of attracting large international grants (e.g. USAID, European Union-EU, MacAIDS) • Flexibility to change as epidemic changes • CSOs' double role: i) human rights & equality advocate; and ii) provision of services or linkage to care.	• Heavy dependency on variable external funds makes CSOs highly vulnerability to external forces. • Lack of capacity to implement pooled resource mobilization. • Lack of specialization by CSOs (i.e. some CSOs do everything instead of focusing on their competitive advantages). • Data collection, performance reporting and financial reporting have been below required international standards in the past. • CSOs do not document enough or routinely, so knowledge and experience may be lost. • CSOs do not invest sufficiently in strategic advocacy responses
Opportunities	**Threats**
• Establish sustainable funding mechanisms at both country and regional levels. • Local production of commodities and bulk procurement. • Formalize CSOs and government partnership through signing of MoU and public financing models such as social contracting • LGBTQI issues receiving international attention and funding opportunities. • Negotiate terms of participation in HIV response with government, including advancing agreement on long-term financing. • Opportunities for private sector partnership. • CSOs leveraging skills for income generation. • Access to technical support from development partners • Explore academic partnerships and utilize findings to attract funding	• Delayed contributions from funding partners which affect implementation and sustainability of programs. • Outbreak of communicable diseases, like COVID-19 can divert resources and attention from HIV/AIDS. • Dependency on external donors will increase unpredictability and flow of resources that ultimately affect provision of and access to services. • Leadership at highest level needed but HIV/AIDS is disappearing from the political agenda. • Political instability, increased instances of human rights violations and gender-based violence that fuels the HIV epidemic. • Older, stronger CSO leadership is moving out of sector but there is no succession planning among younger cohorts.

Source: Jamaica Civil Society forum on HIV and AIDS (2020). Resource Mobilization Strategy 2020-2024

Annex 4. Jamaica Global Fund Contracting Framework

Principal Recipient, Sub-Recipients, Sub Sub-Recipients and Implementing Partners

PR and its Implementing Stakeholders

Principal-Recipient (PR)	Government Implementing Entities	Other Implementing Entities
Ministry of Health	1. Western Regional Health Authority (WRHA) 2. North East Regional Health Authority (NERHA) 3. Southern Regional Health Authority (SRHA) 4. South East Regional Health Authority 5. National Council on Drug Abuse (MoH/NCDA)	1. Children of Faith
	6. Ministry of Health and Wellness/HIV/STI/Tb Unit 7. National Family Planning Board (MoH/NFPB)	Entities collaborating with MOHW/NFPB e.g. • Jamaica Council of Churches (JCC), • Ministry of Labour and Social Security (MLSS), • Office of the Public Defender (OPD), • Social Development Commission (SDC)

Sub-Recipient (SR)	Sub sub-recipients (SSR)	Implementing Partners (IP)
1. Jamaica AIDS Support for Life (JASL)	1. Jamaican Network for Seropositives (JN+) 2. Equality For All Foundation (EFAF) 3. Transwave 4. Jamaican For Justice (JFJ)	1. Eve For Life (EFL) 2. Jamaica Community of Positive Women (JCW+) 3. Larry Chang Centre
2. ASHE Company	NA	1. RISE Life Management Services
3. Children First	NA	1. Hope Worldwide

Annex 5 Sample Interview Guide

Jamaica Sustainability and Transition Strategy Interview:

Interviewee:

Position:

Date:

Introduction:

The objective of our project is to work alongside the sustainability committee and other key partners to transform the TPA developed by Curatio into a costed and prioritized HIV Sustainability Strategy and Action Plan in Jamaica. As part of this process, we will work closely and collaboratively with you to:

•**Synthesize and prioritize** the transition risks that were identified in the 2017 TPA, updated and supplemented with the latest data and analysis

•**Re-examine and refine the recommendations** to mitigate these risks in e.g., financing, procurement, services/KPs, and governance

•**Develop a set of practical short and medium-term actions** including implementation arrangements, costing, and M&E indicators that can be supported by the Government, CSOs and key partners, among others.

Interviewee introduction

Questions (tailored to each interviewee according to profile):

1. What is the current status of HIV surveillance among KPs? What are potential barriers to improving this surveillance as well as linkage to care?
2. The TPA indicates that there are discrepancies in the legal structures allowing CSOs to work with several marginalized communities, namely the LQBTQ community, what are some workarounds for this issue - outside of changing legislation - which would require a significant amount of time and political capital.
3. What is the status of the government's pledge to absorb costs of ARV drugs and lab reagents? Does your office provide epidemiological projections to help prepare the budget?
4. What key partners does her office coordinate with at the parish level? What is the role of each?
5. Was the agency you represent satisfied with the recommendations provided by the TPA? What areas do you think are the most pressing? Are there any gaps that come to mind?

6. Can you tell us more about CVC's experience in Jamaica?

7. Can you describe the current status of civil society and NGO engagement in the HIV response? Is there any ongoing dialogue between CSOs and the Government?

8. What have been the main obstacles to implementing social contracting for HIV in Jamaica? What other examples of social contracting exit within the MoH?

9. Have there been any significant policy changes related to CSO contracting since 2017? Is the ministry aware of such policy barriers? We heard that there were ongoing conversations about this topic, but do you know if there is an official mandate to advance this topic (This is a key area which many of our interviews have emphasized, MOHW is probably best equipped to give technical answer)

10. Overall areas we should focus on outside of costing CSO activities?

11. Has the human rights environment changed in the last 2 years-post TPA? If not, why has this been the case?

12. Has there been any progress regarding the Sexual Offenses Act and the use of the National HIV Discrimination and Reporting and Redress System for case solving?

13. Why wasn't any follow-up after the TPA was finalized? Does the new Committee have ToRs? Anything we could do to help this new Committee to be sustainable? Why wasn't TPA operationalized?

14. What are the synergies you envisioned between NSP and the Transition Action Plan? What can we do to improve integration of the Sustainability Strategy with the National Strategic Plan?

15. What is the main driver of the current HIV epidemic? What is the surveillance (testing) landscape like? - gaps in reaching kep populations - (linkage to care - these a big drop off between testing and ART adherence)?

16. Was PAHOs priorities on the TPA? What is PAHOs role in procurement?

17. The TPA recommends that a dialogue should be initiated with the Ministry of Education to review and institutionalize HIV related training modules that have been created through the GF and other donor-funded programs into the formal education curricula at undergraduate and postgraduate level. Given your role as at CHARES, can you speak more about these programs and if they can feasibly be institutionalized? What about continuous education programs?

18. Growing role of the private sector in the HIV response? How closely does it work with the MoH and other key CSOs?

19. How does the University of the West Indies support the HIV Unit (especially with treatment)? Is there any support with increasing prevention?

20. What was PIOJ's role in the development of the TPA? Can you elaborate more on why it was not endorsed?