DRAFT NATIONAL HIV / AIDS POLICY

JAMAICA

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behaviour Change Communication
CBO	Community Based Organisation
FBO	Faith Based Organisation
ELIZA	Enzyme-linked Immunosorbent Assay
GoJ	Government of Jamaica
HAART	Highly Active Antiretroviral Therapy
HBC	Home Based Care
HIV	Human Immuno-deficiency Virus
IEC	Information, Education and Communication
ILO	International Labour Organization
IOM	International Organisation on Migration
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MOH	Ministry of Health
NAC	National AIDS Committee
NAP	National HIV/STI Control Programme
NGO	Non Government Organisation
OI	Opportunistic Infection
PAC	Parish AIDS Committee
PEP	Post Exposure Prophylaxis
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother To Child Transmission
STI	Sexually Transmitted Infection
UNDP	United National Development Programme
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNTG	United Nations Theme Group on HIV/AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

1.0 Foreword

The National HIV/AIDS Policy is based on the vision of the Government of Jamaica to establish a policy and legislative framework which:

- Promotes the health of the population, individual responsibility for health and the practice of healthy lifestyles
- Protects the rights of people infected with and affected by HIV/AIDS
- Reduces HIV/AIDS-related stigma and discrimination
- Creates an enabling environment for improved access to prevention knowledge, skills and services and for treatment, care and support
- Mitigates the socio-economic impact of the epidemic

The purpose of the policy is to:

- Define the framework for an effective multi-sectoral response to the HIV/AIDS epidemic
- Promote the involvement of all sectors in the national response
- Affirm the rights and responsibilities of persons living with and affected by HIV/AIDS including the most vulnerable
- Provide a framework for assistance and cooperation from international, regional and national partners

This policy provides an overview of the HIV/AIDS situation in Jamaica indicating that the problem is no longer simply a health concern, but a developmental problem that affects the social, cultural, political and economic fabric of the nation. It further identifies the behavioural, economic, socio-cultural and environmental factors driving the epidemic. These factors create and sustain vulnerability to the risk of HIV infection while undermining access to treatment care and support for persons living with HIV and AIDS (PLWHA).

The policy is based on four specific objectives:

- Prevention of new HIV infections
- Treatment, care and support for persons living with and affected by HIV/AIDS
- Mitigation of the socio-economic impact of HIV/AIDS
- Ensuring a supportive policy, regulatory and legislative environment

In keeping with national commitments in the reform of the public service, the policy is based on six guiding principles: political leadership and commitment, good governance, transparency and accountability, multi-sectoral approach and partnership, participation, equity and the promotion and protection of human rights. The policy further supports the 10 ILO principles on HIV/AIDS and the world of work: recognition of HIV/AIDS as a workplace issue, non-discrimination, gender equality, healthy work environment, social dialogue, no screening for the purposes of exclusion from employment or work processes, confidentiality, continuation of employment relationship, prevention, care and support.

The Government of Jamaica will assume the lead role for the implementation of the policy in partnership with civil society including the National AIDS Committee (NAC), private sector, trade unions, non governmental organisations (NGOs) and faith based organisations (FBOs).

Minister of Health
Hon. John Junor

2.0 Introduction

2.1 Background and Purpose of the Policy

HIV/AIDS has become a generalized epidemic in Jamaica that affects the health and well-being of large numbers of people from all social classes and occupational groups throughout the country. However, HIV/AIDS is not only a health problem; it is a developmental issue that affects the social, cultural, political and economic fabric of the nation.

This policy recognizes that an effective response to the HIV/AIDS epidemic requires respect for and protection and fulfilment of all rights - human, civil, political, economic, social and cultural. It also requires that the fundamental freedoms of all people is upheld in accordance with the Constitution of Jamaica and existing international human rights principles, norms and standards.

The principal focus of the national response is the prevention of new HIV infections; the treatment, care, and support of those infected or affected by HIV/AIDS; mitigation of the impact of the epidemic; strengthening of the enabling environment including legislative changes and the reduction of HIV/AIDS related stigma and discrimination. These are seen as mutually reinforcing elements towards an effective response to HIV/AIDS.

Many existing conditions create and sustain vulnerability to HIV infection and heighten stigma and discrimination. Factors driving the epidemic have been categorized as behavioural, economic, socio-cultural and environmental. The practice of multiple sex partnerships for instance pervades the culture particularly among adults between 20 and 29 years. In adolescents, the mean age for sexual initiation is 14 years.[i] For school age children not yet infected, HIV/AIDS issues have not been adequately incorporated into the formal education system. Although a Health and Family Life Education (HFLE) curriculum and a Management Policy for HIV/AIDS in Schools exist, policy direction is needed to help educators own their responsibility in preparing young people as sexual beings.

Findings from the 2004 National Knowledge Attitudes, Behaviour and Practices Survey indicate a higher level of adolescents and young adults in the 15 to 24-age category as delaying the start of sexual initiation.[ii] The survey further shows that risky sexual behaviour such as multiple partner relationships has declined. Overall, males between 15 and 49 years demonstrate more consistent condom use in multiple partner relationships. Both female and males between 15 and 24 years report more consistent condom use in risky situations. Despite widespread awareness of HIV/AIDS and how to prevent it, risk-behaviour among adults had not changed significantly between 1996 and 2000.[iii]

Tourism and population movements, the high levels of unemployment and the increasing importance of drugs and prostitution are included in economic factors. The rate of unemployment for instance was recorded as 15.5% for men in 2000, which is twice as high for women. HIV/AIDS-related stigma and discrimination especially in relation to homosexuality drives those most vulnerable and those infected underground. Also, gender roles and inequities such as female subservience in sexual decision-making influence behaviour choices that spread HIV. There is also a need for even greater sustained commitment to deal with HIV/AIDS from high-level decision makers and leaders in society.

In terms of the supportive environment needed for HIV/AIDS treatment and care, there is still limited access to voluntary counselling and testing, speciality care and antiretroviral (ARV) drugs.

There has been development of HIV/AIDS workplace policies by five public sector ministries and private sector organizations to strengthen interventions through the workplace. These however, are inadequate to create the enabling foundation required from a National Policy on HIV/AIDS.

The purpose of this policy is therefore to:

- Define the framework for an effective multi-sectoral response to the HIV/AIDS epidemic that will reduce the spread of new HIV infections, promote and sustain compassionate care for persons living with HIV/AIDS and mitigate the social impact on those infected, those affected and on the entire society.
- Outline the roles of social institutions and promote the involvement of all sectors of society in the national response to HIV/AIDS.
- Affirm the rights and responsibilities of persons living with HIV/AIDS, of those interacting with them, of people vulnerable to HIV infection and of health care providers.
- Provide a framework for assistance and cooperation from international, regional and national development partners.
- Delineate the mechanisms for effective implementation and monitoring of the policy.

2.2 Situation Assessment

2.2.1 Profile of the Epidemic

Over 40 million people globally are now living with HIV/AIDS. In 2003 alone, five million people around the world were estimated to be newly infected with HIV with 800,000 of them being children. Two-thirds of those living with HIV are in sub-Saharan Africa that has an average prevalence rate of 8 %.

In the Caribbean, half a million people are estimated to be living with HIV/AIDS, which is now the leading cause of death among young adults. The worst

affected countries are Haiti (with a national adult HIV prevalence of over 6%) and the Bahamas (where the prevalence is close to 4%).

Jamaica has an estimated prevalence rate of about 1.5%. Between 1982 and 2003, just fewer than 9,000 persons have been reported living with AIDS with 59.6% of them being male. About 93% of those reported with AIDS have died. All 14 parishes are affected by the epidemic; however the two most urbanized areas, Kingston & St. Andrew and St. James, account for almost 70% of all persons reported with AIDS. Kingston and St Andrew has an infection rate of 514.7 per 100,000 while the rate per 100,000 for St James is 713.5. For every 100,000 persons in the parishes of St. Ann, Westmoreland, Hanover and St. Catherine, 214 are infected with HIV.

HIV/AIDS is having a major impact on working age adults 15–49 years.[iv] Heterosexual transmission continues to be the leading mode of HIV transmission, occurring in more than 60% of persons reported with AIDS. Homo/bisexual transmission accounts for approximately 7%, however, in almost one quarter of persons reported with AIDS, the mode of transmission is not determined.

The epidemic is also taking its toll on children and adolescents. A rapid assessment of orphans and vulnerable children conducted in Jamaica during 2002, estimated that there might be as many as 20,000 children affected by the HIV status of a parent or caregiver. For every thousand pregnant women in Jamaica, 16 are infected with HIV. An estimated 120 or more children under the age of 18 years were orphaned by the loss of one or both parents during 2003. AIDS is also the second leading cause of death in children aged 1 to 4 years. Although infants born to HIV positive mothers are at an average risk of 30%, prevention of mother-to-child transmission can reduce this possibility of vertical transmission to below 5%. Also, adolescent females in the age group 10-19 years had nearly three times higher risk of HIV infection than their male counterparts.

Risk behaviour has declined slightly as revealed in the 2004 Knowledge Attitudes Behaviour and Practices (KABP) survey.[v] Earlier research (2000 KABP) indicated no change in risk behaviour since 1996 despite the high knowledge. The findings showed 24% of the adult male population and 34% of their female counterpart reporting unprotected sexual encounters with a non-regular partner. Multiple sexual partners, early sexual initiation, forced sex, inconsistent to no condom use are among risk behaviours requiring an enabling environment to encourage and maintain changes in attitudes and practice. Typically, men are the sexual decision makers; therefore women have little or no opportunity to negotiate condom use or opt for mutual monogamy.

Men who have sex with men (MSM) and commercial sex workers (CSWs) are among the most vulnerable and are willing to conceal their HIV status and sexual

history from their partners to avoid acts of stigma and discrimination. Commercial sex work although illegal in Jamaica, is widely practised linking CSWs to the general population through their clients and partners. CSWs for their part are a migratory population making it difficult to sustain HIV/STI prevention peer education among them.

Economic factors such as unemployment, prospects for involvement in drugs, prostitution and/or transactional sex influence decisions which increase vulnerability to HIV. A study conducted in 1999 by the Caribbean Epidemiology Centre (CAREC) and the University of the West Indies (UWI) estimated that Jamaica's Gross Domestic Product (GDP) could drop by as much as 6.4% if the current HIV prevalence rate is not addressed. [vi]

The factors driving the epidemic also impede access to treatment care and support. Women in particular, in their roles as caregivers are often disproportionately affected. Societal values and beliefs also restrict access to services such as condoms for adolescents, prisoners and other vulnerable groups.

2.2.2 The National Response

The Government of Jamaica has established a comprehensive National HIV/STI Control Programme. It has indicated its strong commitment to the HIV/AIDS epidemic through:

- Parliamentary approval of the Jamaica HIV/AIDS National Strategic Plan (2002-2006)
- Designation of the National Planning Council (NPC) chaired by the Minister of Finance and Planning as a high-level forum for discussing and advising on HIV/AIDS. The profile of the National AIDS Committee (NAC) has been elevated to a working group of the NPC on HIV/AIDS.
- A mandate issued by Cabinet to five key public sector ministries to prepare and implement HIV/AIDS work programmes within their sectors and to report regularly to Cabinet on progress.
- Approval by parliament of a National Policy for HIV/AIDS Management in Schools.
- Approval of a National Plan of Action for Orphans and Other Children Made Vulnerable by HIV/AIDS (2003-2006).
- A monitoring and evaluation plan and unit established within the Ministry of Health to monitor progress on HIV/AIDS programmes.
- Technical and financial resources through the loan agreement with the International Bank for Reconstruction and Development (IBRD) in the amount of US$15 million and the grant for the Global Fund to fight AIDS, Tuberculosis and Malaria in the amount of US$23 million.
- Negotiations with the private sector to lower consumer prices for antiretroviral (ARV) drugs.

The National HIV/STI Control Programme has responded to the epidemic since 1986 with grant support from the US Agency for International Development (USAID) among other agencies. Since then, the national programme has been improving the technical, managerial and implementation capacity of key players in government and civil society. Over this time frame, the national programme has enhanced the planning, management and implementation capacity of its partners at national, regional and parish levels. The programme has collaborated with other public sector partners, private sector, civil society including faith-based organizations (FBOs), community-based organizations (CBOs) and regional and international bodies. This partnership has resulted in a participatory approach to the components of surveillance, laboratory services, the syndromic management and treatment of STIs, voluntary counselling and testing (VCT), prevention of mother-to-child transmission (MTCT), a prevention programme utilizing the strategy of behaviour change communication (BCC), condom social marketing and training, research, monitoring and evaluation.

While the national programme has had a long history of managing HIV/AIDS/STI interventions primarily through the Ministry of Health and its four regional health

authorities, its outreach was expanded in 2002 to include the Ministry of Labour and Social Security, the Ministry of Industry and Tourism, the Ministry of Education Youth and Culture, the Ministry of Local Government Community Development and Sport, and the Ministry of National Security. The national programme also provides technical and financial support for the National AIDS Committee (NAC), which was established in 1988. The role of the NAC has been strengthened to coordinate effectively the multi-sectoral response to HIV/AIDS issues through its members drawn from government and non-governmental organizations. Members have been recruited to serve on its executive committee or through one of four issues-based committees. The NAC tackles the community response through its Parish AIDS Committees (PACs) and advises Government through its membership in the working group on HIV/AIDS in the National Planning Council.

Jamaica has benefited from a high level of commitment to HIV/AIDS from the Ministry of Health. Successes include the strengthened capacity to manage prevention, treatment, care and support and more recently, policy issues. The expanded support from civil society and government through five key public sector ministries has helped to make the national response truly multi-sectoral.

As a result of extensive behaviour change communication (BBC) interventions, HIV/AIDS knowledge level is high (97%) and condom-use with non-regular adult partners has increased from 37% in 1992 to 67% in 2000. Condoms are also more available in traditional and non-traditional outlets and a 24-hour AIDS/STI Helpline caters to those requiring private and confidential counselling and information.

Through universal antenatal screening and a system of contact investigation, rates of syphilis have declined from 90 per 100,000 in 1987 to 10 per 100,000 in 2000. Health facilities are now more equipped to handle the syndromic management of STIs, contact tracing and treatment; and the laboratory infrastructure has improved. An HIV/AIDS tracking system and behavioural surveillance are also in place. Jamaica is among most countries in the world benefiting from a safe national blood supply and thousands of health workers have also been trained to handle HIV/AIDS issues in the private and public sectors.

The national programme has collaborated with regional and international agencies such as USAID, the Pan American Health Organization (PAHO), the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNPFA), the German Technical Assistance Cooperation (GTZ) and the Caribbean Centre for Epidemiology (CAREC).

The five-year GOJ/IBRD loan agreement (2002-2006) and the grant from the Global Fund to fight AIDS, Tuberculosis and Malaria (2004-2008) have scaled up the national response. Expanded efforts include the implementation of

HIV/AIDS/STI behavioural surveillance; management of opportunistic infections; and training in the treatment of antiretroviral (ARV). The prevention of mother to child transmission programme has grown from its pilot phase to a countrywide undertaking requiring universal Voluntary Counselling and Testing (VCT) for all pregnant women with access to ARV and infant formula.

Gaps in the national response and priority action areas were identified in the NSP (2002-2006). The plan identified the priority areas of (1) policy, advocacy, legal and human rights matters (2) the integrated and multi-sectoral response (3) prevention (4) care treatment and support and (5) monitoring, surveillance and evaluation.

2.2.3 Policy and Legislative Environment

Jamaica requires a National Policy on HIV/AIDS to help it mitigate the socio-economic and health impacts of HIV/AIDS in the society and to improve the quality of life for persons living with HIV/AIDS (PLWHA). The policy will guide the multi-sectoral response to the epidemic through:

- Expanded commitment at the level of government and civil society leadership
- Strengthened framework for action
- Enabling environment to manage effectively the national response

Currently there is no legislation addressing a number of HIV/AIDS-related issues and no framework for reporting and addressing specific acts of HIV/AIDS stigma and discrimination against persons living with HIV and AIDS (PLWHA). Policy development has benefited from draft sector workplace policies, a National HIV/AIDS Workplace Policy and other guidelines and plans of action that have included HIV issues. Among them are guidelines for health care providers in dealing with minors with STIs; the National Youth Policy, Healthy Lifestyles Policy, Early Childhood Policy and Plan of Action and the Plan of Action for Orphans and Vulnerable Children.

Jamaica is also a signatory to the several international and regional conventions and declarations including that from the United Nations General Assembly Special Session on HIV/AIDS (UNGASS), the Convention on the Rights of the Child and the ILO Code of Practice on HIV and the World of Work. The country participates in various regional and international initiatives such as the Caribbean Regional Strategic Plan of Action on HIV/AIDS, the Pan-Caribbean Partnership Against HIV/AIDS (Coalition to fight AIDS), the Nassau Declaration on Health 2001, the Charter of Civil Society for the Caribbean Community and the Platform for Action on HIV/AIDS and the World of Work (2002) in the Caribbean sub-region.

The following strategies towards the development of a policy and legal framework to protect the human rights of persons living with and affected by HIV were delineated in the NSP:

- To develop and enact comprehensive legislation that addresses HIV and human rights, including issues of employment, education, access to care, housing and transportation and to address discrimination in all its forms, including sex, orientation, and disability.
- To develop and enact regulations to be introduced under the powers of the Ministry of Health under the Public Health Act. These regulations will make provisions for issues such as testing, partner notification, contact tracing, duty to treat, duty to warn, duty to inform, informed consent, confidentiality, counselling, experimental research, living conditions in

prison and other places of safety, universal precautions and compensation for health workers.

- To support initiatives for legal protection of HIV infection persons in schools, workplaces and the health care system.
- To develop HIV policy in all sectors.
- To disseminate the legal and policy initiatives to all stakeholders.

3.0 Vision, Objectives and Guiding Principles

3.1 Vision Statement

To protect the rights of all Jamaicans including those infected with and affected by HIV/AIDS and to create an enabling environment free of stigma and discrimination and providing access to prevention knowledge and skills; treatment care and support and other services.

3.2 Specific Objectives

3.2.1. **To reduce the number of new HIV infections through the establishment of a supportive policy/legislative environment** that:

- Promotes responsible sexual behaviour
- Facilitates behaviour change communication strategies and interventions including targeted community interventions
- Increases access to prevention strategies and interventions to promote abstinence, mutual monogamy, consistent condom use and voluntary counselling and testing (VCT).
- Reduces significantly HIV/AIDS-related stigma and discrimination.
- Expands the number of sectors and organizations involved in the implementation of programmes to promote and reinforce prevention methods.
- Integrates the participation of people living with HIV and AIDS (PLWHA) and other vulnerable groups into on-going prevention interventions.
- Encourages social dialogue through the involvement of most vulnerable groups in the design, implementation and evaluation of prevention interventions targeted to them.
- Reduces the vulnerability of those most at risk of HIV/AIDS.

3.2.2. **To strengthen mechanisms for the treatment care and support of persons living with and affected by HIV/AIDS** through a policy and legal framework and enabling environment that:

- Includes increased access to affordable ARV for persons, including children living with HIV/AIDS (PLWHA) and the provision of optimal infant feeding counselling and options for babies born to HIV positive mothers.
- Provides information and support for age-specific adherence and compliance to treatment protocols.
- Assists in normalizing HIV/AIDS allowing uninhibited access to VCT, treatment care and support.

- Provides appropriate guidelines for health workers to administer treatment care and support without any form of stigma and discrimination.

3.2.3. **To mitigate the socio-economic impact of HIV/AIDS on individuals, families, communities and the nation** through a policy and legal framework that:

- Encourages sector, labour force and workplace needs and impact assessments.
- Caters for the needs of HIV-infected and affected employees and establishes reasonable accommodation until such persons are diagnosed medically unfit to perform.
- Promotes home-based care through families, community-based and faith-based organizations.
- Promotes the inclusion of HIV/AIDS in social security benefits and schemes.
- Guides the nation in eliminating HIV screening for job applicants and continuation of employment.
- Encourages the business sector to deal with HIV/AIDS costs and its impact on productivity taking into account prevention and support issues.

3.2.4. **To foster enabling policy regulatory and legislative environment around HIV/AIDS issues including strengthening and sustaining a comprehensive, multi-sectoral response.**

3.2.5. **To affirm the rights of persons living with and affected by HIV/AIDS and the rights of those most vulnerable to HIV/AIDS** through an environment that:

- Reduces HIV/AIDS related stigma and discrimination.
- Improves access to condoms, prevention information and skills, ARV and other treatment for opportunistic infections (OI), infant formula, VCT and family and community support.

3.3 Guiding Principles

In keeping with national commitments in the reform of the public service as articulated in the Ministry Paper: "The Public Sector at Your Service"[vii], this policy shall be guided by the following principles and the 10 key principles of the ILO Code of Practice on HIV/AIDS and the World of Work[viii]:

3.3.1 Political Leadership and Commitment

Strong political leadership and commitment at all levels is essential for a sustained and effective response to HIV/AIDS.

3.3.2 Good Governance, Transparency and Accountability

An effective national response to the epidemic requires leadership to mobilize and manage human, financial and organizational resources in an effective, transparent and accountable manner.

3.3.3 Multisectoral Approach and Partnerships

The active involvement of all sectors of society is necessary to ensure an effective response, including effective partnerships, consultations and coordination with all stakeholders in the design, implementation, monitoring and evaluation of the national response to HIV/AIDS.

3.3.4 Participation

The meaningful involvement of people living with and affected by HIV/AIDS and most vulnerable groups in the design, implementation, monitoring and evaluation of the national response to HIV/AIDS is vital to optimise stated outcomes.

3.3.5 Equity

This principle means that all responses to HIV/AIDS should ensure that no person shall be denied access to prevention knowledge, skills and services or treatment, care and support services on the basis of their real or perceived HIV status, sexual orientation, gender, age, disability, religious or other beliefs, socio-economic status, geographic location, level of literacy, capacity to understand the nature of HIV/AIDS and how it is prevented and treated or vulnerability to exposure. This includes orphans, wards of the state, men who have sex with men, commercial sex workers, street and working children, persons living with disabilities and prisoners.

3.3.6 Promotion and Protection of Human Rights

An important aspect of the response to the epidemic requires that the rights to equality before the law and freedom from discrimination are respected, protected and fulfilled. Discriminatory practices (including unequal gender relations) create and sustain conditions leading to vulnerability to HIV infection and to inadequate treatment, care and support as well as access to prevention services.

3.3.7 Ten ILO Principles on HIV/AIDS and the World of Work

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

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

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

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

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

Non-screening for purposes of exclusion from employment or work processes
HIV/AIDS screening should not be required of job applicants or persons in employment.

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

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

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

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

4.0 The Way Forward

The National HIV/AIDS Policy will help to create the supportive environment for the:

- Development, enactment and dissemination of legislation addressing human rights, including issues of employment, education, access to care, housing, transportation; discrimination in all its forms including on the basis of sex and disability; protection of HIV infected persons in schools, workplaces and the health care system.
- Development, enactment and presentation of regulations under the Public Health Act making provision for issues such as testing, partner notification, contact tracing, duty to treat, duty to warn, informed consent, confidentiality, counselling, experimental research, living conditions in prisons and other places of safety, universal precautions and compensation for health care workers.

4.1 Objective 1 Prevention of new HIV infections

Background
While treatment for persons living with HIV/AIDS (PLWHA) is paramount, the prevention of new HIV infections is the mainstay of the national response to the HIV epidemic. A policy and legislative framework will create the enabling environment to help individuals and vulnerable groups assess and reduce their risk of exposure to HIV.

There is a need to intensify prevention interventions among those at risk including most vulnerable populations such as persons living with HIV/AIDS (and their sexual partners), commercial sex workers (CSW) and men who have sex with men (MSM). Seroprevalence among CSWs is estimated to be 10% to 20% and 25% among MSM. Socio-cultural factors in the society make these groups difficult to reach: for instance, commercial sex work is illegal in Jamaica; widespread homophobia drives homosexuals/bisexuals underground; and stigma and discrimination towards marginalized groups including PLWHA, inhibit their willingness to access health services and prevention information.

The policy and legislative framework will also enable the promotion of prevention programmes developed for and with adolescents and young people to delay sexual initiation, to abstain from sexual activity and to increase condom use among those who opt to remain sexually active. It will encourage the promotion of abstinence and secondary virginity as a viable option while recommending consistent condom use for the sexually active. Gender sensitive approaches must be adopted to maximise the effects of these messages within the context of prevailing social and cultural norms. This is especially important since female adolescents in the age group 15 to 19 are particularly vulnerable because of reported transactional and coercive relationships with older men.

The policy and legislative environment will promote user-friendly environments, pave the way for the full incorporation of HIV/AIDS prevention education into the formal education system, and advocate for the training of popular culture artistes in promoting abstinence and condom use among other things.

While the formal education system provides an ideal environment within which to impart safer sex information, the supportive role of the family, community and faith based organizations is important. The policy will enable the involvement of the family, the community and faith-based organizations (FBOs) in reinforcing appropriate sexual behaviour among adolescents and young people.

The main strategies towards this objective are:

- Developing accurate, culturally appropriate, HIV/AIDS awareness and education programmes with the active participation of the most vulnerable groups including PLWHA groups where applicable.
- Ensuring access to male and female condoms for the prevention of the sexual transmission of HIV.
- Increasing condom use and strengthening condom negotiation skills among women and other vulnerable populations.
- Training and sensitisation of national and community leaders such as teachers, health care workers, tourism workers, adolescents and pastors towards dissemination of HIV/AIDS prevention issues leading to the adoption of infection-free behaviour.
- Advocating for greater involvement of persons living with HIV/AIDS (PLWHA) in the design and implementation of HIV/AIDS education interventions aimed at influencing behaviour modification.
- Disseminating HIV/AIDS information within a life skills context at all levels of formal and non-formal education.
- Strengthening the role of parents and guardians in shaping positive attitudes and behaviours in children and young people with regards to sexuality and gender roles.
- Promoting Voluntary Counselling and Testing (VCT) for HIV, with appropriate pre and post-test counselling, ensuring improved access to vulnerable groups including adolescents and youth.
- Ensuring improved access to all services - education, counselling, partner disclosure, referral, condom access, STI treatment and syndromic management.
- Ensuring safety of blood and blood products and transplants through routine testing and counselling.
- Promoting voluntary disclosure of HIV status to a sexual partner by a PLWHA.
- Strengthening the Prevention of Mother to Child (Vertical) Transmission (PMTCT) including the promotion of universal VCT for pregnant women, access to ARV treatment, counselling and optimal infant feeding options.

- Promoting proper diagnosis and treatment of sexually transmitted infections (STIs) as a means to reduce risk of HIV infection;
- Promoting use of universal precautions of blood borne illnesses, through capacity building and provision of antiretroviral prophylaxis for persons who have experienced occupational exposure to HIV as well as to rape or carnal abuse survivors.

4.2 Objective 2 - Treatment, care and support of person living with or affected by HIV

Background
The Government of Jamaica through the Ministry of Health has scaled up considerably its response to provide treatment care and support for persons living with HIV/AIDS (PLWHA). The establishment of specialized treatment centres in the four regional health authorities will increase access to a national basic standard of care. This includes screening and diagnostic services, counselling, psychological and social support, provision of specialized clinical care and improved access to antiretroviral medications. A policy and legislative framework will enable the National HIV/STI Control Programme through the Ministry of Health to integrate HIV/AIDS case management into the existing health care structures, including paediatric care units with specialist training/treatment centres available at a number of selected sites.

Special services include voluntary and confidential counselling and testing (VCT) services, which is undertaken with informed consent of the individual, and access to ongoing counselling is ensured. Currently VCT sites are established at all major health centres and at all antenatal clinics with over 90% of relevant staff trained in VCT. HIV testing has been decentralized with rapid testing introduced in peripheral clinics.

A comprehensive post exposure prophylaxis programme is to be integrated into the existing infection control programme within health institutions. The programme is supported with access to training manuals and ARV drugs for the prevention of accidental transmission of HIV to health care workers. Medical management of PLWHA also offers nutritional interventions, prophylaxis and treatment of opportunistic and other infections and syndromic management of STIs. A major output of the programme through increased resources from the Global Fund to fight AIDS, Tuberculosis and Malaria is the provision of ARV therapy. The ARV therapy covers the use of appropriate regimes based on national guidelines and protocols to administer different available combinations and manage drug resistance while providing the support system to ensure adherence to the drugs. Services also include palliative care, which covers both home-based and hospice care.

The development of medical management guidelines and the continuous provision of medical education to physicians and other health care providers to

manage combination schemes is being support through collaborative support from the Clinton Foundation, the Inter-American Development Bank (IDB), the United Nations Children's Fund (UNICEF), the UN Agency for International Development (USAID) and the GOJ/IBRD loan agreement. A partnership has been formed with the National Health Fund (NHF) to monitor the distribution of ARV to pharmacies and clients. Private sector access to ARV is being facilitated through Drug Serv pharmacies supplies via HCL. This arrangement allows for the provision of ARV to private patients at government prices. A policy and legislative framework will help to establish the enabling environment for effective management of treatment care and support for PLWHA including the provision of ARV drugs and its adherence and compliance guidelines.

Jamaica's National Plan of Action for Orphans and other children made vulnerable by HIV/AIDS (2003-2006) supports the Jamaica National HIV/AIDS/STI Strategic Plan (2002-2006) while responding to the needs of the National Plan of Action for Children fully in accord with national plans and international agreements, key recommendations from the Plan have been incorporated below to help address the treatment, care and support needs of affected communities, families and children.

Strategies

- Implementing public education campaigns so that every person has access to accurate information regarding HIV/AIDS treatment including where and how to access treatment, care and support. Anti-stigma and behaviour change components will be infused to ensure that myths are dispelled and risk reduction behaviours are simultaneously promoted.
- Expanding VCT access outside of the traditional public health sector to other authorized entities within other sectors to ensure greater coverage of men, young people and other vulnerable groups.
- Strengthening the capacity of families and institutions to care for PLWHA and orphans and other children made vulnerable by HIV/AIDS, including supporting the provision of palliative care inclusive of home-based and hospice care.
- Implementing effective referral and discharge plans for clients by the providers of HIV/AIDS related services and disseminating information on, and facilitating access to, existing social services.
- Training of health care workers in the clinical management of HIV/AIDS; the use of anti-retroviral drugs; the treatment of opportunistic infections and promoting a caring and non-judgemental attitude.
- Regulating and monitoring the procurement prescription storage distribution and sale of ARV drugs to ensure quality control.
- Ensuring the provision of psychosocial support to PLWHA, caregivers and orphans and other children made vulnerable by HIV/AIDS.

4.3 Objective 3: Mitigate the socio-economic impact

Mitigation strategies include the assessment of the economic and social impact of the HIV/AIDS epidemic and the development of multisectoral strategies to address the impact at the individual, family, community and national levels.

Strategies:

- Conducting assessment studies to determine the socio-economic impact of HIV/AIDS on households, the workforce and the nation.
- Building the capacity of the public sector to mitigate the impact of HIV/AIDS by developing and implementing workplace polices.
- Integrating HIV/AIDS workplace policies into corporate plans.
- Facilitating the implementation of the National HIV/AIDS Policy, the National HIV/AIDS Workplace Policy, other HIV/AIDS sector workplace policies, and the National Policy for HIV/AIDS Management in Schools
- Facilitating the implementation of the National Plans for HIV/AIDS/STI and orphans and other children made vulnerable by HIV/AIDS, guiding expanded multisectoral responses especially in the area of socio-economic development
- Involving the Attorney General's department in the preparation of appropriate legislation that address HIV/AIDS human rights and discrimination.
- Treating as the utmost priority the rapid scale up of access to ARV for PLWHA, including parents and caregivers
- Advocating that there is no justification for HIV screening as a prerequisite for employment and/or termination of employment.

4.4 Objective 4: Enabling policy regulatory and legislative environment

The realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS. Respect for the rights of people living with HIV/AIDS is an essential and central component of an effective response. Discrimination against people living with HIV/AIDS violates their rights and is counterproductive to an effective response. People living with HIV/AIDS also have a responsibility to respect the rights and health of others. Participation of people living with HIV/AIDS in the design and implementation of HIV/AIDS programmes is essential to an effective national response to the epidemic.

Strategies

- Reviewing existing policy guidelines and legislation to determine the current situation and gaps:
    - Expand current policy guidelines facilitating access of contraceptives (including condoms) to sexually active minors (under 16 years) to include access to VCT and ARV services
- Revising policies and guidelines in keeping with best practices.

- Amending legislation to minimize human rights violations:
    - Amend VD act
    - Ensure that women and girls are protected against violence, including sexual violence, rape and other forms of coerced sex.
    - Access to prophylaxis, treatment, and effective recourse in event of coerced sex, including complaining mechanism, investigation and punishment.
    - Address gender imbalance where men cannot be raped.
- Developing new policies and legislation where gaps exist:
    - Permit testing without consent for diagnosis of an unconscious patient in the absence of a parent or guardian, where the same is necessary for purposes of optimal treatment.
    - HIV post-test counselling programmes should involve strong and professional efforts to encourage, persuade and support HIV positive persons to notify their partners. In exceptional cases whereby a properly counselled HIV positive person refuses to disclose his or her status to sexual partners, the healthcare provider will be able to notify those partners without the consent of the source client. This beneficial disclosure shall be subject to appropriate and explicit guidelines to be developed by government in accordance with International Guidelines on HIV and Human Rights.
- Ensure that HIV/AIDS is mainstreamed into strategies and programmes to address poverty reduction.
- Strengthen and enforce existing legislation to protect children and young people against any type of abuse and exploitation with particular reference to the new Child Care and Protection Act (2004)
- Incorporate age appropriate reproductive and sexual health education into the early childhood, primary and secondary school curricula for all students and school personnel and ensure that similar reproductive and sexual education is made accessible to youth out of school to protect them from HIV and other STIs.

5.0 Implementation of the Policy

5.1 Management and Coordination

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

The National HIV/STI Control Programme headquartered in the Ministry of Health has responsibility to coordinate the national response, provide leadership and technical guidance, and address the mobilization of adequate local and international resources for an effective response to the epidemic. Sector ministries, NGOs and private sector entities will implement various aspects of the policy. Strengthening and sustaining partnerships between the Government and all relevant stakeholders is critical to the success of the policy. The National AIDS Committee (NAC) will continue to be, a key player in this regard as it members represent *inter alia* the tripartite team of government, employers and workers, the vulnerable population including PLWHA, the donor community, the private sector and civil society.

Implementation Strategies

- Mainstreaming HIV/AIDS issues into all relevant policies, plans and programmes or establishing a specific focal point in each organization.
- Strengthening the role of the NAC in advising the Government of Jamaica on HIV/AIDS issues based on best practices, and coordinating the involvement of stakeholders and partners, including adolescents, youth and other vulnerable groups in the implementation of the national response.
- Ensuring that resources for HIV/AIDS are allocated and managed to ensure an effective and efficient national response.

5.2 National HIV Research Agenda

HIV/AIDS research is required to address gaps in existing knowledge about HIV/AIDS and to inform policy, practice and HIV/AIDS related interventions.

Implementation Strategies

- Promoting epidemiological, biomedical and social sciences and operational research in order to provide sound, scientific and reliable information to guide national HIV/AIDS policy, practice and interventions. All HIV/AIDS related research involving human subjects should satisfy ethical and human rights considerations of Jamaica-based and partner

institutions according to the standards of international best practices whilst respecting national cultural sensitivities and norms.

- Strengthening the capacity of those research bodies on which shall be included representation from government and NGO sectors to advise and monitor HIV/AIDS related research.
- Promoting wide and timely dissemination of national and international HIV/AIDS research results.
- Fostering the collaboration of international HIV/AIDS researchers in Jamaica with local institutions.
- Promoting genuine community and stakeholder participation in the planning and execution of research involving human subjects.
- Promoting collaboration with academic institutions and institutional research partners to conduct sophisticated research in all aspects of HIV/AIDS including basic science and prevention, clinical and HIV vaccine trials.

5.3 Rights and Responsibilities of Stakeholders

Government is a facilitator, to ensure coherence and coordination of the national response including setting the comprehensive and inclusive legislative and policy framework, within an environment of multi-sectoral participation. The Government of Jamaica is also an implementer, through the delivery of health protection and promotion, clinical services, development of guidelines, social protection research, financial resources and enforcement.

Civil Society needs to partner with government to implement various aspects of the policy, but also has a watchdog role to ensure that government fulfils on its commitments. Civil society, through faith based organizations, community based organizations, non governmental organizations and the private sector also has the responsibility to advocate for interventions in keeping with fulfilment of human rights for all; and care for those infected and affected. There is an imperative that all stakeholders ensure that they provide accurate HIV-related prevention information and education as well as care and support for people living with HIV/AIDS and not make false claims of HIV/AIDS cures or promote behaviours that increase the risk of HIV infection.

Persons living with HIV/AIDS (PLWHA) – need to be involved in all aspects of policy development, implementation and evaluation. The policy will help to affirm the rights of PLWHA; to ensure that exclusion from work, social services or participation in events is not based on their HIV status; to normalise HIV/AIDS by reducing stigma and discrimination associated with it; to improve the quality of life for PLWHA; and to reduce the risk of infection by PLWHA through adherence to consistent condom use or abstinence. No person should be obliged to disclose his or her HIV status for purposes of employment or social involvement. PLWHA have the responsibility to ensure that they do not willingly or unwilling spread HIV and to be involved in lobbying for access to interventions and legal redress.

Most Vulnerable Groups

Adolescent and Youth have the right to knowledge of HIV modes and transmission and prevention methods of abstinence, mutual faithfulness and consistent condom use. They have the right to participate as a key resource during policy and programme development, implementation and evaluation and given the opportunity to voice their concerns about strategies and interventions developed for them. Strategies designed for students within the formal education system should be determined with the involvement of the Ministry of Education Youth and Culture. Both in-school and out-of-school adolescents and youth should have access to culturally appropriate, gender and age sensitive interventions and support material within a life skills context. No child should be denied a place in school on the basis of real or perceived HIV status. Health care providers including pharmacists should not deny minors access to condoms on their request, but should offer services, guidance and counselling while promoting abstinence as a viable option in a non-judgemental way. Low-literacy approaches and the use of edutainment should be utilized for effective communication to this population group, especially to those who are sexually active and/or are at the risk of sexual exploitation. Street and working children are examples of those who maybe sexually active and at risk for sexual exploitation.

Street & Working Children have the right to HIV prevention knowledge and skills including abstinence, condom-use, and to treatment, care and support, protection from statutory rape, sexual assault and VCT

Commercial sex workers have a responsibility for protecting themselves, their clients and their sexual partners from the risk of HIV infection. They should have access to peer education training, condoms, condom-use and condom negotiation skills, VCT and proper diagnosis and treatment of STIs. More user-friendly clinics should be established and sustained to improve the non-threatening access of CSWs to prevention information, skills and services.

Men Who Have Sex With Men - Although Jamaica's HIV/AIDS epidemic is primarily driven by heterosexual sex; men who have sex with men (MSM) are among the most vulnerable population group. Recent baseline research has confirmed that homophobia in Jamaica is the most lethal cultural influence which forces MSM underground.[ix] MSM should have the right of access to prevention knowledge, skills and services and to treatment care and support within a non-threatening environment.

Inmates should not be denied the right to access prevention knowledge, skills and services and voluntary counselling and testing. They should have access to treatment, care and support. Access to HIV/AIDS/STI prevention information, treatment care and support should take into account protection from rape, sexual violence and coercion. Juveniles should be segregated from adult inmates to

protect them from abuse. Inmates should not be subjected to HIV testing without their informed consent, isolation or any form of quarantine on the basis of real or perceived HIV/AIDS status.

6.0 Monitoring Evaluation & Review

Monitoring and evaluation (M&E) is essential to assess the impact of the national response and provide recommendations for future policies, strategies and interventions. M&E is a highly technical and specialized field that requires appropriate expertise. Reports are required from such experts to be able to assess progress and amend previous strategies and interventions if necessary. The policy will enable the selection of the M&E team by the appropriate body and will facilitate its access to information, on-site observations and interaction with relevant groups and individuals.

Objective: To develop and sustain a system for the effective collaboration, management and dissemination of data on HIV/AIDS – incorporating indicators as set out in the national plans and the UNGASS Declaration.

Specific activities include:

- Maintaining and strengthening passive and active surveillance for HIV/AIDS through HIV/AIDS/STI sentinel surveillance and periodic behavioural surveillance among specific groups.
- Strengthening capacities to monitor and evaluate programmes including the development and review of indicators.
- Establishing a national HIV/AIDS data management system with linkages to other national data collections systems.
- Facilitating regular dissemination to partners and the general public.

The National HIV/AIDS Policy shall be reviewed every five years, a process that could take place at the same time as the review of the Strategic Plan of Action, and utilizing similar indicators defined by the Plan of Action. The goal and strategies will be reviewed to ensure relevance to the current national situation around HIV/AIDS.

Implementation Benchmarks

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

HIV/AIDS policy and implementation plan of action

- All organisations/workplaces have at least designated a Focal Point on HIV/AIDS with a working link committee representing management and employees and a PLWHA with consent.
- All organisations/workplaces have a policy framework – guidelines or a full policy such as the National HIV/AIDS Policy, the National HIV/AIDS Workplace Policy, a Sector Policy on HIV/AIDS or an adaptation.

- All organisations/workplaces monitor and evaluate the HIV/AIDS policy and programme implementation.

Non-discrimination

- All formal and informal sector organisations/workplaces report zero-tolerance for discrimination and actively implement the principle of greater involvement of people with HIV/AIDS in the workplace.
- All formal and informal sector organisations/workplaces promote the principles on which the national policies are based including the 10 key principles from the ILO Code of Practice on HIV/AIDS and the world of work.
- No formal/informal sector employee/member/visitor is discriminated against on the basis of real or perceived HIV status.

Prevention and training

- At least 90% of formal or informal sector group of employees/members can name at least three ways to protect themselves from HIV.
- All formal and informal sector employees/members have access to training/learning opportunities on HIV/AIDS prevention.
- All committees and training teams have a gender balance approach to training.
- Female and male condoms are accessible and/or available with instructions for their use.

Care and support

- All formal and informal sector employees/members have access to or reliable referral to 100% Voluntary Counselling and Testing (VCT) and antiretroviral treatment (ARV).
- All formal and informal sector organisations/workplaces offer or reliably refer employees/members to a range of care and support options regardless of perceived or real HIV status

Appendix I

Basic Facts on HIV/AIDS

The Human Immunodeficiency Virus (HIV) causes AIDS (Acquired Immune Deficiency Syndrome). HIV only affects humans. It does so by gradually weakening the immune system making it difficult for the body to fight infection. HIV is microscopic and can only survive in cells that are living while destroying them.

Modes of Transmission

HIV is transmitted from an infected person to another through blood and blood products, semen (and pre-ejaculation fluid), vaginal fluids and breast milk. Transmission of HIV takes place in four main ways:

- Unprotected sexual intercourse with an infected partner - anal (high-risk), vaginal (high-risk), oral (low-risk)
- Blood and blood products (through for example, infected transfusions, organ or tissue transplants or the use of contaminated injection or other skin piercing equipment)
- From infected mother to child in the womb or at birth (25% to 50% chance of transmission to child without treatment and as low as 5% chance of transmission with treatment and infant-feeding substitutes to breast milk)
- Through breast-feeding

HIV is NOT spread during everyday casual contact

HIV CANNOT be transmitted during casual, physical contact with an HIV positive person such as coughing, sneezing, kissing, hugging, sharing utensils, toilets and washing facilities or consuming food or beverages handled by the person. Mosquitoes and other insects do NOT spread this virus. A person CANNOT get HIV from the air, from food and from water.

To get HIV:

- HIV must be present
- HIV must be present in enough quantities to infect (blood, semen, vaginal fluid, breast milk)
- HIV must go directly to the blood stream.

A person cannot get HIV by handling or coming into contact with the tears, sweat, saliva and urine of an HIV infected person. There is insufficient concentration of HIV in these body fluids to cause infection.

It is very difficult to determine someone's HIV status by just looking at the person. Someone infected with HIV can look and feel well for up to 10 or more years without showing signs and symptoms of illness. This person however, can transmit the virus to others especially during unprotected sexual intercourse.

A person has to be HIV positive and diagnosed with at least two major and one minor opportunistic illness before being regarded as having AIDS. Early symptoms of AIDS include chronic fatigue, diarrhoea, fever, mental changes such as memory loss, weight loss, persistent cough, severe recurrent skin rashes, herpes and mouth infections and swelling of the lymph nodes. Opportunistic infections such as cancers, Meningitis, Pneumonia and Tuberculosis may also take advantage of the body's weakened immune system. AIDS is fatal, although periods of illness may be interspersed with periods of remission. There is still no cure for AIDS. While research continues to develop a vaccine against HIV/AIDS, none is as yet viable. Jamaica is able to increase access to antiretroviral drugs because public/private sector partnerships and a grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria have helped to lower the cost to a person living with HIV/AIDS. Typically, ARV drugs are expensive and therefore out of the reach of majority of those needing them.

Prevention

HIV is fragile and is only able to survive in a limited range of conditions. It can only enter the body through naturally moist places and cannot penetrate unbroken skin. To prevention transmission of HIV, it is recommended that all sexually active persons use a barrier to the virus such as a latex male condom during every episode of sex. The female condom is also recommended. To prevent transmission through accidental exposure to blood and other (relevant) body fluids, universal precautions should be adopted. This requires the use of protective equipment such as rubber masks and gloves in situations involving exposure to blood and other body fluids from an infected person. Skin-piercing equipment should not be contaminated by re-use without proper sterilization. Bleach, strong detergents and very hot water kill the virus rapidly, which is unable to survive outside of a living human body. Persons who are exposed to blood accidentally through skin puncture by an injection needle or those raped are required to undergo HIV testing and post exposure prophylaxis.

Prevention of Sexual Transmission

- Abstain - This method of prevention is strongly recommended for children and adolescents and is appropriate for members of faith-based organisations (FBO) and other groups who practise delaying sex until "the right time".
- Be faithful to one sexual partner who is uninfected and mutually faithful.
- Correct and consistent condom use
- Do get tested

Prevention of Blood Transmission

- Universal Precautions
- Post Exposure Prophylaxis
- Protected national blood supply
- Advocacy to prevent sharing of IV drug needles including provision of sterilized needles

Prevention of Mother-To-Child Transmission

- Universal HIV Testing of Pregnant Women
- ARV treatment for all HIV positive pregnant women
- Counselling for all HIV positive pregnant women on treatment
- Access to information, counselling and follow-up care and support for all HIV positive pregnant women, including family planning services and nutritional support
- Advocacy for the provision of specific guidance and support to ensure adequate replacement feeding

How To Tell Your HIV Status

- Get tested.
- ELIZA TEST - The most common method of HIV testing conducted in Jamaica is the use of the ELIZA (Enzyme-linked Immunosorbent Assay) test for screening and the Western Blot test to confirm the result. If the result is positive from both tests, it means that antibodies to HIV have been found in the blood.
- RAPID TEST - The Rapid Test is being made available at established treatment centres throughout the four health regions. This method is faster but not as specific as the ELIZA test.
- VCT (Voluntary Counselling & Testing) – HIV testing should be voluntary or with informed written consent. It should be preceded (pre-test) and followed (post-test) by counselling. Through counselling the client is able to understand what the negative test result means and what the positive test result means. The appropriate sexual behaviour for any kind of result should be discussed with the client during counselling. Group education may be provided in lieu of individual pre-test counselling. However, all post-test counselling should be conducted without breaching the privacy and confidentiality of the client.

Window Period

- When a person is exposed initially to HIV – that is becomes infected through contact with an infected person – it may take between six weeks and up to three months before antibodies to HIV are detected in the blood. Antibodies are created as the immune system tries to fight off the infection from the virus.
- The HIV test looks for antibodies. When these antibodies are detected the person is diagnosed HIV positive.
- A person can be positive and the test shows negative because the test was carried out during the window period.

Who Needs To Take An HIV Test

- Sexually active people – This includes even those who are currently abstaining who were sexually active up to 10 years ago.
- People with more than 1 sex partner – This applies to those who have been engaged in serial monogamy.
- People who have unprotected sex.
- People who use condoms inconsistently and incorrectly.
- People who have doubts that their sex partner is faithful.
- Anyone who was raped should get tested for HIV.
- Anyone who got accidentally stuck by an injection needle while attending to a client/patient.

Taking the HIV Test

- The client should:
    - Know what the test results mean before and after taking the test.
    - Get counselling before and after taking the test.
    - Use condoms during every sexual encounter or abstain.

How To Use the Male (Latex) Condom

- Ensure there are sufficient latex condoms within easy reach. Check the expiry date and the manufacturer's date on the package. Feel the package before opening to detect air, which means the product, is not damaged. The penis must be erect before putting on the condom.
- Open the package carefully to avoid damage to the condom. Avoid the use of sharp openers such as teeth or nails. After removing the outer package, hold the tip of the condom between the thumb, middle and index fingers and expel the air.
- Ensure that the condom is on the side that will roll out naturally. Roll the condom two notches down to allow for sufficient space at the tip. While

holding the tip of the condom unroll it onto the penis keeping the position until your hand reaches the base of the penis.

- Use a water-based lubricant with the condom. Some condoms are already lubricated.
- After the male partner ejaculates (cum) pull out the penis while it is still hard to prevent the spillage of semen. Remove the condom carefully ensuring that your fingers do not come in contact with the semen in the tip of the condom. Take note of the colour of the semen in the condom. Discoloured semen may indicate the presence of another sexually transmitted infection (STI). Once the condom is removed tie the end of it and dispose in the garbage bin. Wash hands.
- If the couple desires to continue having sex, wait until the penis gets hard again and put on a new condom.

How To Use The Female Condom

- The female condom can be inserted up to eight hours before sex. Most women insert between 2 to 20 minutes before sex.
- The female condom is for one-time use and should be removed before the woman stands.
- Practise using the female condom without having sex.
- To insert the condom, find a comfortable position such as standing with one leg up on a chair, or sitting with knees apart or laying on back
- Ensure that the inner ring is at the bottom, closed end of the pouch. The condom is lubricated, however, extra lubricant may be added to the tip of the pouch and to the outer ring.
- Hold the pouch with the open end hanging down. While holding the outside of the pouch, squeeze the inner ring with the thumb and middle finger. Place the index finger between the thumb and the middle finger and keep squeezing the inner ring.
- While squeezing the female condom with three fingers, use other hand to spread the lips of the vagina and insert the squeezed female condom.
- If the female condom is slippery during insertion, let it go and start over.
- Use the index finger to push the inner ring and the rest of the pouch into the vagina. The inner ring should go just past the pubic bone, which can be felt with the index finger.
- Ensure that the female condom is not twisted when it enters the vagina.
- About one inch of the open end of the female condom will remain outside of the body. Once the penis enters the vagina will expand and the slack will decrease. Use your hand to guide the penis into the vagina.
- To remove the female condom, squeeze and twist the outer ring to keep the seminal fluids inside the pouch. Pull out gently. Discard the used condom in the trash bin.[x]

Sexually Transmitted Infections and HIV Transmission

- People who have been diagnosed with another sexually transmitted infection (STI) are at risk for HIV. Persons with STIs are more likely to have sores and small breaks in the skin and lining of their genitals. It is easier for HIV to enter the body through these breaks. (Herpes, Syphilis, Gonorrhoea, other STIs with sores). If a person has an STI or has had one, h/she could have contracted HIV because of unprotected sex.

Risk Assessment For Sexual Transmission

Answer YES or NO to each of the following questions. If the answer to all or most questions is NO your risk for contracting HIV is high.

Risk Assessment	YES	NO
Abstinence is appropriate and easy for me to sustain.		
I am sure that my current sexual partner is uninfected and is having or has had sex with only me and he/she is equally sure about my faithfulness to him/her.		
I use a condom CORRECTLY, EVERYTIME, I have sex.		
I am absolutely sure that I did not get a sexually transmitted infection during my last sex act.		
I know my HIV status.		
I know my partner's HIV status.		
I am sure that my partner is having sex with just me and I am his/her first and only sexual partner.		
I am able to convince my partner to use either the male condom or the female condom every time we have sex.		
I took an HIV test recently and the result was negative and I'm sure that it was not in the window period.		

The 3 Ifs of Risk Perception and Appropriate Action:

1. If you have had sex even one time during the past 12 months, this risk assessment applies to you.
2. If you don't intend to delay sex for the rest of your life, it also applies to you.
3. If your answer to all or even one question is NO,
    - Consider taking an HIV test,
    - Using a condom during your next sex act or
    - Delaying sex until you are sure there will be no risk of exposure to HIV.
    - Call the HELPLINE – 1-888-991-4444

Appendix II

Universal Precautions

- These precautions apply to all persons regardless of their presumed infection status.
- They are a simple standard of infection control practice to be used in the care of all patients at all times to minimize the risk of blood-borne pathogens.
- Universal precautions consist of:
    - Careful handling and disposal of sharps (needles and other sharp objects)
    - Hand-washing before and after a procedure
    - Use of protective barriers – such as gloves, gowns, masks – for direct contact with blood and other body fluids
    - Safe disposal of waste contaminated with body fluids and blood
    - Proper disinfection of instruments and other contaminated equipment
    - Proper handling of soiled linen

Appendix III

Acknowledgements

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