Integration of HIV Programming in the Latin America and Caribbean Region (Jamaica Country Report)

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ABBREVIATIONS AND ACRONYMS

CCM	Country Coordinating Mechanism
CRSF	Caribbean Regional Strategic Framework
CSO	Civil society organisation
EDPs	External development partners
GF	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GoJ	Government of Jamaica
HP+	Health Policy Plus Project
KP	Key population
LAC	Latin America and the Caribbean (region)
MOHW	Ministry of Health and Wellness
NAC	National AIDS Committee
NFPB	National Family Planning Board
NHP	National HIV Programme
NSP	National Strategic Plan
OPM	Office of the Prime Minister
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PLHIV	People living with HIV
RHA	Regional Health Authority
RSSH	Resilient and sustainable systems for health
SDGs	Sustainable Development Goals
SR	Sub-recipient
SRH	Sexual and reproductive health
UHC	Universal health care
UMIC	Upper Middle-Income Country
USG	United States Government
WHO	World Health Organization

EXECUTIVE SUMMARY

Jamaica is one of the countries within the Latin America and the Caribbean (LAC) region which has committed, through the 2015 Sustainable Development Goals (SDGs) to end the epidemics of HIV/AIDS and achieve universal health coverage (UHC) by 2030. It is estimated that there are 32,617 adults living with HIV with 16.2% undiagnosed and unaware of their HIV status. Jamaica has a generalised HIV epidemic (1.5%) among adults with concentrated epidemics in key populations.

Integrated People Centred Health Services (IPCHS) was proposed by the World Health Organization (WHO) as a method for improving the efficiency of health services and expanding coverage to meet population needs so that no one is left behind. Although there is not a single agreed definition of integrated health services WHO describes them as services that are patient-centred and provide a continuum of care from *"health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs throughout the life course"*. For the health sector the aim of integrated services is to bring about greater efficiency in healthcare delivery, increasing coverage and accessibility as it relates to quality and range of services as well as affordability for the consumers and suppliers of these services and achieving better health outcomes. Jamaica does not currently deliver IPCHS but has committed to achieving this in their vision 2030 strategy.

In order to continue supporting countries to implement sustainable HIV responses while contributing to UHC, the Global Fund commissioned the Euro Health Group (EHG) to carry out an independent review on the status of integration efforts in the Jamaican public health system in October 2019. The objectives of the review were to:

1. Assess the level of integration of the HIV programme within the health system in terms of governance, financing, management systems and service delivery
2. Identify bottlenecks at different levels of the system to operationalise integration, including cross-programme integration of policies, planning, processes, institutional capacity and health financing
3. Identify opportunities for incremental integration, ensuring key principles of the HIV response are retained (e.g. participation of people affected by the disease)
4. Provide options to relevant stakeholders on how integration can lead to a more sustainable response
5. Inform a facilitated country discussion and development of a feasible roadmap for incremental integration

The methods used to carry out the review desk included document reviews, key informant interviews and consultations with key stakeholders in Jamaica and among international development partners. The main review parameters focused on: 1) political Commitment and governance; 2) client/patient/ user needs and feedback; 3) delivery of health services (HIV and other services); and, 4) supporting RSSH Infrastructure. These parameters were selected in accordance with WHO five strategic areas that are considered critical for the successful transition and integration of national HIV programmes.

Findings

Political commitment and governance
- The concept of integration of health is endorsed as a central theme of the health sector vision 2030 and the strengthening of primary health care and facilities. This is also reflected in the latest draft NSP for HIV 2020-2025 and confirmed in a key informant interview with the NSP Committee Chairperson. Therefore, political declarations for an integrated governance and

service delivery approach to integration are well documented and supported by the senior leadership in the Ministry of Health and Wellness (MOHW).

- The concept of integration of health services is not new in Jamaica and the GoJ has made multiple efforts towards integration in the past years. In 2013 previous efforts at integration of HIV and sexual and reproductive health (SRH) were initiated by a decision to move the HIV programme from the MOHW and place it under the auspices of the National Family Planning Board (NFPB). However, the GoJ decided to retain the HIV treatment component under the MOHW, which effectively resulted in a split and weakening of the HIV programme and limited the implementation of the integration of HIV and SRH. There is currently a legal process taking place to reverse this decision. Other efforts towards integration undertaken in Jamaica include: a) increase of domestic investment in the HIV response; b) integration of training for the clinical management of HIV, cross staff; c) establishment of a HIV/STI/TB Unit; d) placing HIV testing, treatment, care and support services in primary and secondary care; e) supporting CSO organisations to develop treatment services; f) absorbing essential cadres of HIV dedicated staff incrementally into health care worker cadres and g) clinical guidance for HIV treatment care and support that includes standard and enhanced packages of care

- Although documents speak to health sector reform, integration and a primary health care model of service delivery, this assessment notes that there is not a common understanding of what integration means for the Jamaican context and there is lack of clear guidance on which integrated model/s of care Jamaica envisions to be applied.

- Furthermore, Jamaica does not currently have a functioning multi-sectoral coordinating body to guide current and future integration efforts. A review of the framework documents, and perceptions from all of the interviewed stakeholders shows that the MOHW has the capacity, expertise and authority to manage the implementation and integration of the HIV programme and related health services in the public sector and is the only body in the country with this authority, expertise and capacity.

- CSO participation in the HIV response has increased substantially during the past decade with, for example, CSOs being active members of the JCCM, including holding leadership positions, and a number of other formal and informal ways in which key population communities participate in decision-making on HIV issues. Therefore, they are well-integrated in the HIV response and there is a strong desire by all stakeholders to ensure they remain programmatically and financially viable.

Delivery of health services (HIV and other services)
- HIV treatment care and support and prevention services in Jamaica are delivered in primary and secondary care facilities in the four health regions managed by the respective regional health authorities, the Public Health Clinics and the Hospitals. Currently, a vertical programme and disease management model is applied in the primary, secondary and tertiary health system. Out of the 332 health clinics in the country, HIV treatment is only offered at 49 public health clinics, which is less than 15% of facilities; however, greater coverage has been established with approximately 74% of hospitals (17 out of 23) housing HIV outpatient treatment clinics.

- A recent list of HIV treatment sites is given in Annex 5 and treatment map which shows, at best, a partial integration of treatment as modalities differ from site to site and region to region and with most only offering HIV services on certain days. The High Burden HIV Site Map in the main body of the document demonstrates where the top 20 HIV treatment sites are

located and the other services that are available from the same location. This map typifies HIV treatment and co-located services in the higher-level public health clinics, hospitals and specialist services across the country, suggesting some level of integration with primary, secondary and tertiary health care services.

- Various inefficiencies have been identified in the current structural arrangements of the MOHW and the RHAs necessitating a revision of roles, functions and responsibilities of these entities. A few stakeholders noted that the decentralisation of authorities for service provision to the Regional Health Authorities (RHAs) was challenging and contributed to the non-standardisation of services and the general fragmentation of the health sector. Further, the institutional arrangements that govern service delivery are challenged by poor reporting requirements, performance targets set on an ad hoc basis, and a lack of action for non-compliance with reporting or missed targets. These are important elements in the overall health sector that should be taken into consideration when defining the operational plan for HIV integration.

- Human resources for health (HRH) has been and continues to be a primary constraint for the integration of HIV programming. HIV programme staff include a Regional HIV Coordinator, a Regional Behaviour Change Communication (BCC) Coordinator and parish BCC Coordinators. Treatment sites have doctors, nurses, social workers, adherence counsellors, case managers, psychologists, community peer educators and nutritionists. A 2014 Human Resource Analysis for HIV Services revealed that overall, the full time equivalent (FTE) of currently deployed health care workers in the field is 62% of the optimal level required. PEPFAR's sustainability index concluded that a significant proportion of the staff providing HIV services are not fully institutionalized which is a sustainability risk. However, since then the MOHW has increased funding for human resources and assumed previously funded PEPFAR posts. Furthermore, a particular challenge to integration was that historically there has been a significant health worker resentment towards the relatively well-funded HIV programme, when other areas of the health service have been poorly resourced. Therefore, there is little incentive for over-burdened health care workers to expand their roles especially in the context that HIV funding is being reduced.

Client / patient / user needs and feedback
- For service users to assess what the benefits and the drawbacks of integration might be they first have to understand what an integrated service will look like and how it will be delivered. They were of the view that currently HIV services are delivered by a few trained and sensitised HIV staff, but outside of this context there is a great deal of S&D towards PLHIV and KPs by people working in the health sector. Therefore, they feared that HIV service quality might be compromised under a primary health care model but were keen to note they have seen improvements in the reduction of S&D.

- Currently there are no policies to minimize and apply sanctions for S&D by healthcare workers or by other services users in the health sector but recent initiatives to document S&D include SIDney which is an integrated platform to record, analyze and exchange information on human rights violations to inform policy and programs, and JADS, which collects and investigates complaints of HIV-related discrimination across Jamaica and refers them to the appropriate entities for redress.

Supporting RSSH and Health Management Infrastructure
- Being able to make evidence-based decisions either at the macro-level (HIV programming), meso-level (e.g. budgeting) or at the micro-level (patient care) is based on having information and data which is valid, trustworthy, precise, reliable and timely. At all three levels, most

stakeholders noted that multiple HIS continue to operate in silos, and that there is a strong need to integrate these systems that was stated in the e-Health Strategic Plan 2014/2018. Additionally, currently there are no tools, processes or guidance to facilitate the cross-disease joint monitoring and stakeholders noted a need to eliminate parallel reporting systems.

- Interviewed stakeholders consider, both the procurement and lab systems to be fully integrated into the national system. Antiretroviral (ARVs) and other health products are procured using the government's pharmaceutical procurement and distribution system.

- Ministry of health revenue comes from various sources including registration of pharmacies and drugs, drug permits, sale of prescription drugs, parents' contributions toward maintenance of children in state care, Advisory Panels on Ethics, external grants and donations, as well as, miscellaneous sources of revenue. Costing of Jamaica's HIV response was included into the country's multi-year budget plans with HIV having its own line items and commitments. Contributions by the GoJ to the HIV response in 2016 and 2017 were estimated at 38% and 32% respectively. The GoJ's financing commitments are for: 1) human resources; 2) the use of health care facilities; and, 3) ARVs, reagents, and test kits.

The reviewers found a number of incentives and bottlenecks to advance the integration of HIV services including:

Opportunities and Incentives for Integration

- **Change in external funding landscape**- GoJ anticipates a decline of external assistance due to the change in Jamaica income classification (move to upper middle-income country). Therefore, the need for improved efficiency is a main driver of integration.
- **Increasing Uptake of HIV Treatment Services & Improve Health Outcomes & Targets -** HIV programme staff and EDPs desire greater health outcomes for PLHIV towards meeting UNAIDS 90-90-90 and a healthcare system that meets international standards and leaving no one behind.
- **Reduce Stigma and Discrimination** - CSOs are primarily driven by a desire to make HIV services more accessible and less stigmatized for the key populations that they serve.

Integration Bottlenecks

- **Election cycles**- While integration of the HIV response is a long-term goal, governments use to prioritize short terms wins.
- **Stakeholder skepticism based on previous experiences**- The failure to facilitate the integration of HIV into SRH and the detrimental impact that had in the HIV program brings skepticism about the feasibility to advance on the integration of the HIV response.
- **Human resources shortages-** According to interviewed stakeholders and in the documents reviewed, there is a shortage of healthcare providers with high turnover and attrition rates. Therefore, for currently overburdened healthcare workers there are few incentives for them to assume more responsibilities for the HIV programme that may arise when integration takes place.

Conclusions

While the political commitment which Jamaica has shown toward integration is commendable, there needs to be a discussion about reaching a shared definition of "integration" and what that implies for the various levels at which integration might occur and what is possible given the limited fiscal space. The responsibility for articulating this vision is clearly within the MoHW's and the GoJ's purview. For example, the MoHW/GoJ might choose to focus on delivering health services via a patient-centered and team-based primary health care model which would focus on a horizontal case management approach

with team members assigned to patients according to need and in consultation with patient and caregivers. Similarly, health services could be provided in a vertical–horizontal synergy model in which vertical disease specific service delivery programmes are maintained, but, horizontal integration occurs across services for a patient-centered holistic approach to health care. Most recently, as outlined in the recent NSP the idea was put forward to deliver HIV in an integrated sexual and reproductive health model at service delivery points which would offer integrated service delivery of HIV, family planning, and maternal and child health. There might also be the option to consider a combination of the options at different service delivery sites based on capacity, need and patient load. The following table outlines some options for consideration and the advantages and disadvantages of each.

Integration Options

OPTION 1 [1]	ADVANTAGES	DISADVANTAGES
Model: Patient Centred Team Based Primary Care Horizontal case management approach-team members assigned to patients according to need in consultation with patient and caregivers How to achieve it? Establishing an integrated governance framework Led by laws/ policy and operational guidance/directives Instituting new and amending existing protocols Reconfiguring health teams Training/reorienting/skilling up staff/ Task shifting Establishing an integrated health information/reporting system	Well established that patient centred care improves the quality of health care, reduces costs and improves patients' clinical outcomes (WHO) Minimises traditional boundaries/territories that exist within the healthcare system. Patient-centred care can be employed by primary care teams in any specialty and is effective across disease types. Improved patient provider relationship, satisfaction Increases efficient use of diagnostic testing, prescriptions, hospitalizations, and referrals. Promotes preventative care and patient ownership/involvement in their care Allows involvement of community teams/CSO/differentiated care approach/Social contracting Reorients staff to patient centred health care delivery partnering in decisions about their own care/responsibilities Flexible/dynamic approach with staff/teams' makeup according to needs Reduces stigma and discrimination by removing HIV-specific sites (and services)	Requires substantial investment to reform health sector delivery Major reform of health governance structures & organisation/staff structures/policies and procedures/Requires major Health System Strengthening Accommodates MOHW direction for case management approach Requires increased staff cadres/staff to deliver approach Extensive training of staff and reorientation of organisational culture Risk loss of specialism that vertical approach offers/reduced quality of care HIV program target focus might be diminished in system wide approach
OPTION 2 [2]	ADVANTAGES	DISADVANTAGES
Model: Vertical–Horizontal Synergy Model Maintain vertical disease specific service delivery programmes but ensure horizontal integration across services via referrals for a patient centred holistic approach to health care. How to achieve it?	Less costly than Patient Centred Team Based Primary Care Model Minimal reform of health governance structures & organisation/staff structures Maintenance of disease specific technical expertise Maintain quality of vertical programmes Minimal upheaval of current service delivery arrangements	General health services are weakly developed when vertical disease specific approaches are applied which affects ability for vertical programmes to reach their targets (WHO) Health System strengthening might not have the same urgency

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[1] High Level Policy Brief-Accelerating UHC: Ending Epidemics of HIV, TB, Malaria and other Communicable Diseases, through Integrated People- Centred Health Service, WHO/ADGO/CDS/Global Fund

[2] WHO (https://www.who.int/bulletin/volumes/83/4/editorial10405/en/)

Led by policy and operational guidance/directives	Minimal need to recruit/increase staff cadres	Status quo might be maintained with no improved efficiencies (e.g. long waiting times)
Instituting new and amending existing protocols/	Minimal disruption to service users and patient provider relationships	Staff need to be trained/might be resistant to training and task shifting/HR/Labour laws considerations /consultations
Training/reorienting/skilling up staff/	Ability to maximise relational health status between provider and patient to engage in discussions about other health needs and health screening	
Task shifting		Staff overburden/lack of motivation
Developing referral pathways	Broadens skill set across health sector/maximises the efficiencies of current staff	Less scope for cost efficiencies might
Expanding/integrating health information/reporting systems	Expands surveillance and M&E/facilitates cross sharing of information sharing/enhances strategic Information	Services might still be stigmatised
	CSO and Private sector providers can contribute more to vertical programmes	

OPTION 3[3]	ADVANTAGES	DISADVANTAGES
Model: Integrated SRH Model (HIV/FP/MCC) at Service Delivery Points (SDP)	Less costly than Patient Centred Team Based Primary Care Model & Vertical Horizontal Models	Narrower focus on SRH/ignores wider health of person
Strategic sites (SDPS for integrated service delivery of HIV/FP/MCC)	Brings synergies across select programmes targeting reproductive age-group at strategically located SDPs (PEPFAR, 2013)	Excludes person not in reproductive age range
How to achieve it?	Accommodates NFPB/MOHW integration focus	Risks loss of HIV focus
Led by policy and operational guidance/directives	Maintains focus of FP/MCC and HIV	Might result in the exclusion/loss of KP focus (Traditionally female oriented)
Instituting new and amending existing protocols/	Takes a broader approach to SRH and is not disease specific	Staff need to be trained in use of new protocols/&HIV/MCC & FP-might be resistant to training and task shifting/HR/Labour laws considerations
Training/reorienting/skilling up staff/ Task shifting	Results in a horizontal approach to service delivery	
Developing referral pathways	Flexible/integrations can take place at HIV SDPs or FP SDPs (PEPFAR 2013)	Staff overburden/lack of motivation
Expanding/integrating health information systems	Holistic SRH approach to PLHIV/broadens disease/treatment focus	
	Offers more support to PLHIV	
	Expands HIV response/prevention/testing to SRH/FP service users	
	Reduces stigma and discrimination	

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[3] Monitoring the Integration of Family Planning and HIV Services; Freyder et al, Measure Evaluation 2016

1 REVIEW BACKGROUND AND PURPOSE

1.1 Background

Jamaica is one of the countries within the Latin America and the Caribbean (LAC) region which has committed, through the 2015 Sustainable Development Goals (SDGs) to end the epidemics of HIV/AIDS and achieve universal health coverage (UHC) by 2030. Integrated People Centred Health Services (IPCHS) were proposed by the World Health Organization (WHO) as a method for improving the efficiency of health services and expanding coverage to meet population needs so that no one is left behind. Although there is not a single agreed definition of integrated health services WHO describes them as services that are patient-centred and provide a continuum of care from *"health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs throughout the life course"*. WHO recommends five key strategies for the successful transition to IPCHS and deciding which diseases and health services in the country are best suited to integration.[4] The strategies include:

- Strengthening governance and accountability and addressing health inequities that expose people to catastrophic expenditure by ensuring better health allocations, particularly priority PHC programs to achieve better health outcomes.
- Engaging and empowering people and communities in the development and implementation of policies and priority plans that directly impact primary health care.
- Reorienting models of care so that they are safe, accessible and affordable for everyone and underpinned by a human rights-based approach by well-trained health professionals.
- Coordinating services within and across sectors adhering to the same national policies, strategies and plans across all sectors, using gender-sensitive approaches, through joint actions and shared responsibility.
- Creating an enabling environment in which individuals and communities are empowered and engaged in maintaining and enhancing their health and well-being.

Integrating health services does not necessarily mean that all services must be integrated nor delivered in a single location but rather organized in ways that different services are readily linked to assist patients to easily navigate towards the services that meet their needs and to make health provider referrals more efficient for the continuity of care. The following diagram shows six examples of how health services can be organized for integrated approaches with cross-cutting features among them (WHO).

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[4] High Level Policy Brief-Accelerating UHC: Ending Epidemics of HIV, TB, Malaria and other Communicable Diseases, through Integrated People- Centred Health Service, WHO/ADGO/CDS/Global Fund

Table 1. WHO Integrated HIV Approaches[5]

1. Integrated packages of preventive and curative health interventions for a particular population group. Often distinguished by its stage in the life cycle, such as childhood, adolescence through to adulthood so that a target group receives all the appropriate interventions	2. Multipurpose service delivery points – a range of services for a catchment population is provided at one location and under one overall manager. Examples include multi-purpose clinics, multipurpose outreach visits and a hospital with the management of all its services consolidated under one governance arrangement- from the user's perspective is an opportunity to receive coordinated care, rather than having separate visits for separate interventions	3. Continuity of care over time. This may be about lifelong care for chronic conditions such as HIV/AIDS, or a continuum of care between more specific stages in a person's lifecycle, for example, antenatal, postnatal, newborn and child health.
4. Vertical integration of different levels of service, for example, district hospitals, health centres and health posts-. In this form of integrated health service there are well-functioning procedures for referrals across the different levels of the system and between public and private providers.	5. Integrated policy-making and management which is organized to bring together decisions about different parts of the health service, at different levels.	6. Working across sectors with institutionalized mechanisms to enable cross-sectoral funding, regulation or service delivery-E.g. health working with education services to develop effective school health promotion campaigns.

For the health sector the aim of integrated services is to bring about greater efficiency in healthcare delivery, increasing coverage and accessibility as it relates to quality and range of services as well as affordability for the consumers and suppliers of these services.

1.2 Aim and purpose of the review

In order to continue supporting countries to implement sustainable HIV responses while contributing to UHC, the Global Fund commissioned the Euro Health Group (EHG) to carry out a review on the status of integration efforts in Jamaican public health system in October 2019. The aim of the review was to generate information and evidence to be used by Jamaican stakeholders, the Global Fund and partners to inform the planning and implementation of integration efforts and the need for technical and financial support from local and external development partners. This included exploring the possible options for integration based on the country situation and the review findings. It is hoped that the review can assist the country in advancing integration of the national HIV program within the broader national health system including scaling up coverage of priority interventions, improving treatment cascades, finding cost efficiencies, and assisting Jamaica to achieve the ultimate goals of improved coverage, access, quality, acceptability, and better health outcomes. The full Terms of Reference (ToR) is presented in Annex 1 of this report.

The objectives of the review were to:

1. assess the level of integration of the HIV programme in the rest of the health system in terms of governance, financing, management system and service delivery;
2. identify bottlenecks at different levels of the system to operationalise integration, including cross-programme integration of policies, planning, processes, institutional capacity and health financing;

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[5] High Level Policy Brief-Accelerating UHC: Ending Epidemics of HIV, TB, Malaria and other Communicable Diseases, through Integrated People- Centred Health Service, WHO/ADGO/CDS/Global Fund

3. identify opportunities for incremental integration, ensuring key principles of the HIV response (e.g. participation of people affected by the disease) are retained; and,

4. provide options to relevant stakeholders on how integration can lead to a more sustainable response;

5. inform a facilitated country discussion and the development of a feasible roadmap for incremental integration.

2 COUNTRY BACKGROUND

It is estimated that there are 32,617 adults living with HIV with 16.2% undiagnosed and unaware of their HIV status. Jamaica has a generalised HIV epidemic (1.5%) among adults with concentrated epidemics in key populations. See Table 1. (Revised UNAIDS Estimates November 2019).

Table 2. Jamaica Country Epidemic Data[6]

Generalised Epidemic	Population Estimates	Percent	Source:
Population	2.7 million		STATIN, 2019
Estimated persons living with HIV (PLHIV)	32,617		Revised UNAIDS Estimates, 2019
Estimated diagnosed and aware of their status	27,324	83.8%	Revised UNAIDS Estimates, 2019
Jamaicans unaware of their HIV status	5,293	16.2%	Revised UNAIDS Estimates, 2019
Concentrated HIV Prevalence in Key Populations			
Transgender Women	3837	51.0%	(876 Survey, 2017)
MSM	42,375	29.6%	(876 Survey, 2017)
Homeless in 2015		13.8%	(Skyers et al 2018)
STI Clinic attendees Male/Female		3%/7.3%	(MOH 2017)
Prison inmates-		6.9%	(Bailey et al, 2019)
FSW >than general population		2.0%	(MOH 2017)

The scale up of HIV test and treat programmes supported by the Global Fund and PEPFAR funding has resulted in diagnosing people earlier so that fewer PLHIV discover their status when they are in the advanced stage of the disease. However, there are still significant gaps in the treatment cascade that need to be prioritised in order to reach 2030 elimination targets for new HIV infections. The challenges include[7]:

- 5293 (16.2%) people that are unaware of their HIV status
- 14,824 (45.4 %) people that know their HIV status but have been lost to follow-up
- 12,500 (50%) people that are on treatment but are not virally suppressed

Vision 2030 sets out six strategic goals in its commitment towards equitable health care delivery and accelerating UHC by implementing essential packages of health services based on the epidemiological profile of the country and population needs. The six strategic goals conceptualized to achieve Vision 2030 are:

Goal 1: Safeguarding access to equitable, comprehensive and quality health care

Goal 2: Strengthening the stewardship capacity of the MOHW to improve leadership and governance to achieve universal access to health and universal health coverage

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[6] Draft National Strategic Plan 2020-2025
[7] Ibid

Goal 3: Increasing and improving health financing, equity and efficiency and commitment to the mission

Goal 4: Ensuring social participation and inter-sectoral collaborations to address the social determinants of health

Goal 5: Social participation and inter-sectoral collaborations to address the social determinants of health

Goal 6: Making reliable and modern infrastructure available for health service delivery

All public health services in Jamaica are governed by the MOHW that set the government's policy, technical and clinical standards. The government has service level agreements with four regional health authorities (RHA) in the south, south east, north east and western regions of the country. The RHAs are responsible for overseeing service delivery and implementation of the government strategies and interventions coordinated by the parish health departments. Parish Health Departments are responsible for the day to day delivery of a range of health services and the management and supervision of staff through a network of 332 public health clinics spread across the four regions and based on population demand.

3   REVIEW METHODS AND LIMITATIONS

This review was conducted by an independent team consisting of a Team Leader and a local consultant both of whom are public health experts and bring significant knowledge of the health systems within the LAC region and internationally. The review team engaged in remote consultations with the GF Country Team and other key stakeholders in the Secretariat and provided an overview of the data collection process to in-country counterparts prior to the start of the in-country review mission. Guiding both the data collection and analysis was the overarching framework which focused on "integration" in relation to both the governance function of the health system as well as service delivery and is based on the following WHO and World Bank recommended principles as shown below.

Table 3: Overarching Principles for Assessment[8]

Principle	Explanation
Participatory & inclusive	Include all relevant stakeholders in the health sector, including government, donors and development partners, private sector, civil society and people affected by the disease (ensuring key principles of the HIV response)
Analytical	Base it on "a causal framework of how inputs, processes, and outputs interact with each other and with other important environmental factors" and "to understand the current situation based on past decisions, choices, and plans, as well as underlying causal factors".
Relevant & focused	Consider how health sector reforms in Jamaica could bring about improvements in health system performance; by focusing on the "issues that ultimately affect the health status of the population", and "consider solutions to ongoing challenges".
Comprehensive	Cover all dimensions of the health sector in Jamaica and its performance, including health systems, organisational structure and institutions, characteristics of inputs and processes, the full range of public and private health services, demand and community engagement, the total market etc..
Evidence-based	Utilise multiple sources of quantitative and qualitative information and data about the Jamaican health system, lessons learned from similar assessments, and where relevant, other countries' experiences.

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[8] Adapted from WHO 2016

3.1 Data sources and data collection methods

3.1.1   Data sources

Primary data was collected through individual and group interviews, either face-to-face or by skype/phone. The review team conducted a preliminary stakeholder mapping, based in part on discussions with the GF Country Teams and documentation and then used a cascade approach to identify further key stakeholders. The review team used semi-structured questionnaires to collect qualitative data during interviews. The review team used the questionnaires flexibly during interviews to tailor questions to the specific knowledge and experience of the interviewee or focus group participants. To encourage openness and honesty in responses, participants were assured that all responses would be treated in strict confidence and responses would not be traceable to individual respondents. Information was to be analysed entirely by the review team, collected data was anonymised, and analysis of the results are presented in aggregated form only; though, unattributed quotes were used if they were particularly illustrative of an issue.

Secondary sources of data included, for example, Global Fund documentation, national level strategies both specific to HIV and the health sector in general, internal and external programme evaluation reports, additional relevant studies, and any documentation that the review team, the GF Secretariat, or country stakeholders believed to be relevant. A full list of documents reviewed is given in Annex 3 of the report.

3.1.2   Data collection methods

Three main methods of data collection were employed to conduct the review. This included:

    1) desk review of key documents;

    2) remote interviews, and

    3) in-country key informant interviews (individually and in groups).

The in-country visit presented an opportunity to assess the current status of HIV programme implementation, governance mechanisms, interactions between various health services, the real political commitment to HIV integration, and the perceived advantages and disadvantages of integration as given by users and providers of HIV and other health services. The in-country work also examined the extent to which planning, management and supporting RSSH infrastructure have been harmonised/integrated and coordinated between programmes or with other special initiatives. The team inventoried and documented the involvement of relevant stakeholders, especially civil society and healthcare providers, in HIV integration, and the potential effects that changes might have on the ability to provide and access a continuum of services.

3.1.3   Data Analysis

The review team analysed primary and secondary data to respond to the main review parameters and related primary and secondary questions. The main areas for the assessment were: 1) political commitment; 2) client/patient / user needs and feedback; 3) delivery of health services (HIV and other services); and, 4) supporting RSSH Infrastructure. These parameters were selected in accordance with the strategic areas as articulated by WHO for the successful transition and integration of national HIV programmes. Corresponding questions were developed based on discussions with the Global Fund around specific areas of inquiry and what was feasible for the timeframe for the review (see Annex 2: Review Matrix for further details). Data analysis took place both during and after fieldwork activities were completed.

Quantitative Data Analysis: Quantitative data was derived from secondary data sources such as reports and research, however, the data available was limited in scope.

Qualitative Data Analysis: This review is primarily based on qualitative data from key informant interviews and group discussions. The review team used a systematic approach to interpreting, and understanding the information received such that a thematic content analysis was derived. Team members prepared detailed, compiled, organised, and uploaded that information into a team Dropbox. This allowed team members not only to discuss received information immediately after completion of interviews, but, also to verify the validity and integrity of their interview notes. This allowed any discrepancies between team members' notes to be discussed and resolved.

3.2 Limitations

The team identified a number of limitations to the review. These include:

1) *Qualitative information* - The review draws heavily on the opinions of key stakeholders involved in the oversight, implementation and monitoring of HIV and other health programming. It is acknowledged that these opinions may be, at least partly, subjective and may also reflect specific vested interests. The team sought to mitigate the subjectivity of opinions by triangulation of both methods and data.

2) *Representation* - The review team identified a large and diverse group of stakeholders at the global and country levels; however, given the limitations of a five-day in-country mission by the review team not all stakeholders were available to be interviewed during the review timeframe and it was not feasible to obtain complete representation of all of the various stakeholders. For example, there are four heads of the Regional Health Authorities in Jamaica and the review team was only able to remotely interview two of them. Similarly, the review team was only able to meet with a very limited number of healthcare service providers (see Annex 2 for the full list of individuals interviewed). Additionally, there may have been self-selection bias in that some stakeholders choose to be included into the interview pool while others may have declined

3) *Recall* – Some of the information collected was retrospective in nature and there may have been recall bias, especially for programmes, policies, and initiatives which began earlier. In addition, it must be recognised that stakeholder opinions about HIV integration may vary based on current and/or future real or perceived benefits or drawbacks. Therefore, information collected may have been affected by recency bias. For example, as will be discussed further in the Findings, there have been previous (and current) discussions and policies put in place about HIV integration. Depending on the timing of the interviews with stakeholders, their opinions about integration may be influenced by those additional efforts.

4) *Data insufficiency and discrepancies* –Some of the referenced reports are still in draft and have not been approved by the Cabinet of Ministers and, therefore, cannot be fully utilized and generally there is a lack of specific research around Jamaica's health sector reform and historical integration efforts. However, as noted below, when possible, the review team did include the most recent and relevant information it was able to access.

4 FINDINGS

4.1 AREA OF ENQUIRY: POLITICAL COMMITMENT AND GOVERNANCE

4.1.1 Political commitment and governance

The concept of integration of health services is not new and has in fact been endorsed as a central theme of the health sector vision over the past 20 years at the regional and country level.

The Caribbean Regional Strategic Framework on HIV and AIDS (CRSF)[9], as early as 2002 included the integration of HIV services as one of its priority areas for member countries.

In 2013, the GoJ took considerable efforts to integrate its HIV and family planning programmes. The HIV programme at the time was managed by the Ministry of Health and the Family Planning Programme by a quasi-government entity, the National Family Planning Board that was established under an act of parliament in 1970. The Act gave the NFPB the authority to, among other items, coordinate efforts around family and population planning, provide for sex education, and operate and collaborate with Government and other bodies in operating clinics and other institutions concerned with maternity and child welfare and family and population planning. The NFPB had its own autonomy, separate governance arrangements and was led by an independent board.

According to stakeholders that were interviewed, the decision at the time to integrate family planning with HIV was to bring greater synergy of service delivery, expand the reach of the HIV programmes and generally place HIV within an all-encompassing sexual and reproductive health framework. The decision was also taken as HIV programmes were encouraged to endorse the UNAIDS "Three Ones" principle of One National HIV Plan, One Authority and One Monitoring and Evaluation Framework. To fulfill the one authority principle, the NFPB was seen by stakeholders as the only entity with the legal capacity to fulfill this function and oversee the implementation of a national strategic plan under the 1970 National Family Planning Act.

At that time, the National AIDS Committee, established shortly after the launch of Jamaica first National STI/HIV programme in 1988, with the intention of bringing together multi-sectoral stakeholders, CSO and key populations to develop an integrated governance approach to the HIV response, was not fulfilling their assigned roles and there was a lack of clarity about the NAC's functions and operations (Transition Readiness Assessment).

Following the integration of the HIV programme and family planning, the NFPB developed a new National Integrated Strategic Plan for Sexual and Reproductive Health and HIV for 2014-2019 (NISP 2014-2019). The plan provided a blueprint for achieving the vision of an integrated programme while supporting the achievement of the Millennium Development Goals and the emerging themes in the 2030 Jamaica sustainable development goals agenda. The approach to the development of the NISP was highly integrative and consultative involving all key stakeholders including government, civil society, private sector, HIV affected communities, youth, faith-based organizations, academia and international development partners.

The plan for the NFPB to be the sole coordinating entity for the integrated HIV response was complicated by the GoJ decision to retain the HIV treatment component under the MoHW, which effectively split the HIV programme. As it currently stands, the MoHW, through the National HIV/STI Programme is responsible to lead on coordination of the national response, provide leadership and technical guidance, and address the mobilization of adequate local and international resources for an effective response to the epidemic. It is also responsible for the coordination of treatment, care and support services, health and laboratory system strengthening, surveillance and strategic information. The NFPB, on the other hand, has been tasked with the responsibility to coordinate training activities related to HIV prevention and M&E and lead on policy and planning for enabling environments and the greater involvement of PLHIV.

The general view from all parties is that the split in the HIV programme with the separation of HIV treatment from prevention has been a major barrier to achieving integration and has weakened efficiency and the efficacy of the programme. Unfortunately, most stakeholders said that the actual implementation of HIV efforts under the NFPB were sub-optimal as there were numerous leadership

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[9] Caribbean Regional Strategic Framework on HIV and AIDS, CARICOM/PANCAP, 2014

changes. There was also a high turnover of staff among the technical expertise that were transferred from the HIV programme in the MOHW to the NFPB and the NFPB staff generally lacked the experience or expertise to successfully oversee the HIV programme and its integration. It is agreed by all stakeholders that the MOHW is the only body within the country with the authority, legal capacity and technical expertise to manage the implementation of the HIV programme and related services in the public sector. It also sets the regulatory framework for all health services and standards in public, private and CSO health care settings.

Finally, GoJ's is now going through a legal process to officially merge the NFPB within the MOHW but how exactly they will be integrated into the MOHW and the HIV/STI/TB unit is currently unclear based on stakeholder interviews and reports. However, there was a high-level agreement and confidence among key informants across sectors that the current senior leadership in the MOHW, namely the Permanent Secretary (PS) has demonstrated an understanding of the complexities of the HIV programme and the response and a commitment to integration and as is seen as a crucial driver of this process. Reviewers interviews with the PS and documented evidence of the actions that have been taken and willingness to engage in examinations of the current health system for health reform planning also confirm this.

The Revised National HIV Policy 2017 states "The National AIDS Committee (NAC) will continue to be, a key player in this regard as its members represent inter alia the tripartite team of government, employers and workers, the vulnerable population including PLHIV, the donor community, the private sector and civil society.". Thus, it is unclear whether there are plans to revitalize the NAC, merge it with the CCM, if this statement was made in error, or it was referring to the current CCM as the NAC is no longer in existence. In any case, there is a perceived need among stakeholders to define an appropriate model to coordinate the multi-sectoral HIV response, which is both within the GoJ hierarchy and maintains civil society presence, especially in advance of transitioning from donor funding.

Jamaica within its own Vision for Health 2030: Ten Year Strategic Plan 2019-2030[10] also set the agenda for change through strategic goals including integrating health promotion and health services promoting healthy lifestyles. In this context Jamaica is well positioned to progress integrated HIV health services and decide how best to define and operationalize integrated care based on national priorities, disease burden and available resources.

4.1.2   Progress towards Integration Under the National Strategic Plan 2014-2019

The reviewers did find strong evidence from the desk review and the interviews, however, that outside of formal cabinet sanctions for the implementation of the NISP, the GOJ and the MOHW made substantial commitments, took critical decisions and made significant systematic efforts with the goal of sustainability and integration of particularly the HIV treatment care and support components of the national response Through the implementation of the NISP 2014-2019. They include:

- Increasing domestic investment in the HIV response
- Ensuring that the clinical management of HIV disease is part of medical and nursing training in formal education and training institutions.
- The NFPB spearheaded the cross training of HIV and family planning among respective staff to increase the number of staff that could provide integrated HIV & SRH services and reduce duplication and costs.[11]

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[10] Vision for Health 2030: Ten Year Strategic Plan 2019-2030, Ministry of Health and Wellness
[11] TPA UNAIDS 2017 and Interviews

- The Ministry of Health & Wellness (MOHW) established a HIV/STI/TB Unit effectively integrating HIV/STIs and TB for policy, treatment, surveillance, and quality and standard setting purposes.
- The MOHW placed HIV testing and treatment care and support services in primary and secondary care and supported CSO organisations to develop treatment services to maximize reach and accessibility for all, including men-who-have sex with men, transgender people and sex workers by ensuring differentiated treatment models were available.
- Integrated the procurement of ARVs and other HIV related health commodities into other MOHW procurement processes, such as the National Health Fund and committed domestic funds to ensure the availability of free-of-charge ARV treatment services at HIV treatments sites, in select private pharmacies and private practitioners through public-private agreements.
- Integrated routine HIV screening into ante-natal and post-natal health care in primary and secondary care, delivered by midwives and non and other non-dedicated HIV staff.
- Absorbed essential cadres of HIV dedicated staff incrementally into health care worker cadres.
- Developed clinical guidelines and protocols for the integrated management of HIV, STIs, TB and mental health that defines standard and enhance packages of care.
- Strengthened and integrated laboratory services and capacities and the lab information systems.
- GoJ is also working with PEPFAR to establish centres of excellence in order to pilot new standards for health with improved HIV treatment and care and access for KP.

4.1.3   Stakeholder commitments to integration

The following table summarizes the level at which reviewers assessed stakeholders' commitments to integration:

Table 4. Stakeholder Commitment to Integration

STAKEHOLDERS	COMMITMENTS TO INTEGRATION
GOJ-Senior Leadership	Partially, through; policy declaration but not adequate financial investments
MOHW Staff-Senior Leadership	Partially committed but skeptical as they perceive push back from front-line health care workers -cited are historical resentments towards the HIV programme that was very well resourced when other aspects of the health service were struggling with limited resources and staff[12]
National HIV/STI/TB Unit-Senior Leadership	Fully committed-need to improve treatments cascades-90-90-90 and improve access for all
Regional Health Authorities-Senior Leadership	Fully committed-need to improve treatments cascades-90-90-90 and improve access for all
MOHW Staff-Front Line Health Workers	Unable to assess commitment first hand during review but perceived to be partially committed by MOHW senior staff
EDP	Fully committed but not in agreement with integration modalities, PEPFAR piloting centres of excellence models and PAHO promoting UHC
CSO	No clear consensus on integration-lack of understanding of what it will mean and which models of integration and HIV treatment modalities in particular will benefit KP-But keen to see improvements in health services in general in keeping with the health for all approach and leaving no one behind. Also, would like CSO continued involvement in the HIV response

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[12] A consistent theme in interviews with MOHW staff and EDPs

STAKEHOLDERS	COMMITMENTS TO INTEGRATION
Key Populations	No clear consensus on integration-lack of understanding of what it will mean and whether it will be beneficial for KP or not. Want non-identifiable HIV services at public health clinics.

4.2 AREA OF ENQUIRY: DELIVERY OF HEALTH SERVICES (HIV AND OTHER SERVICES)

First-Level Care health centres are categorized by type from 1 to 5 according to the type of services they are equipped to provide and the population size that they serve. (Type 1 offering the minimum of services to a population of 4000) Type 2 -population 12,000 and types 3- 5 population 20,000 offering the more comprehensive primary care services). RHAs also manage secondary care through 23 public hospitals and tertiary care facilities that provide specialist service such as TB and HIV in some instances.

Jamaica does not currently deliver a Primary Health Care model (i.e. PHC serves as an entry point for all services with referral linkages) but has committed to achieving this in their vision 2030 strategy and through the ongoing training and the development of different staff categories of health care workers such as Nurse Practitioners and Community Health Aides to name a few and training physicians in family medicine.[13]

Integration of HIV with other health services is variable at service delivery points; but, determining the level of 'integration' is predicated on how stakeholders conceive and define integrated service delivery**.**

HIV prevention, treatment care and support services are governed by the ministry through its HIV/STI/TB Unit. HIV prevention treatment care and support services are delivered in 49 island-wide sites, mainly from the type 4 and type 5 health facilities and in a few instances from the lower level clinics according to accessibility needs in deep rural location. The MOHW also has Memoranda of Understanding (MOU) with a small number of governmental organizations and private sector entities involved in the HIV response for prevention, treatment, care and support and M&E. Figure 1 shows the current organizational structure. Of note is that the governance body is not named and the JCCM is omitted.
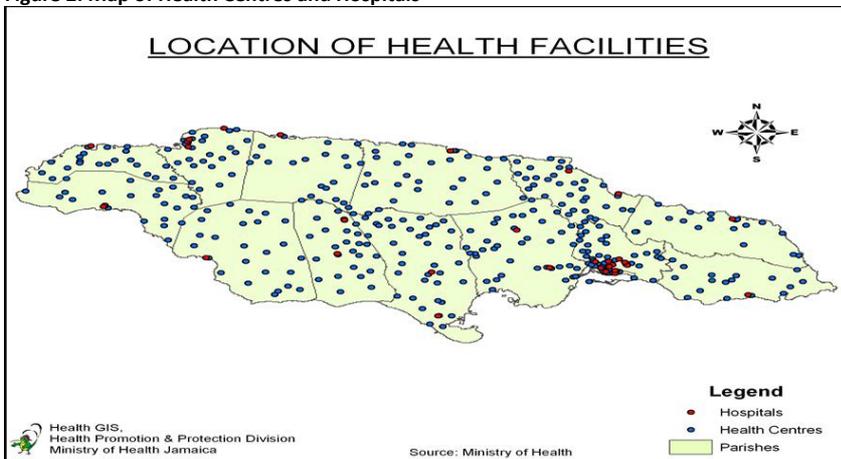
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[13] Jamaica Development of Workforce for First-Level Care, Country Case Studies on Primary Healthcare, WHO 2018

Figure 1. STI Programme Structure & Human Resources[14]
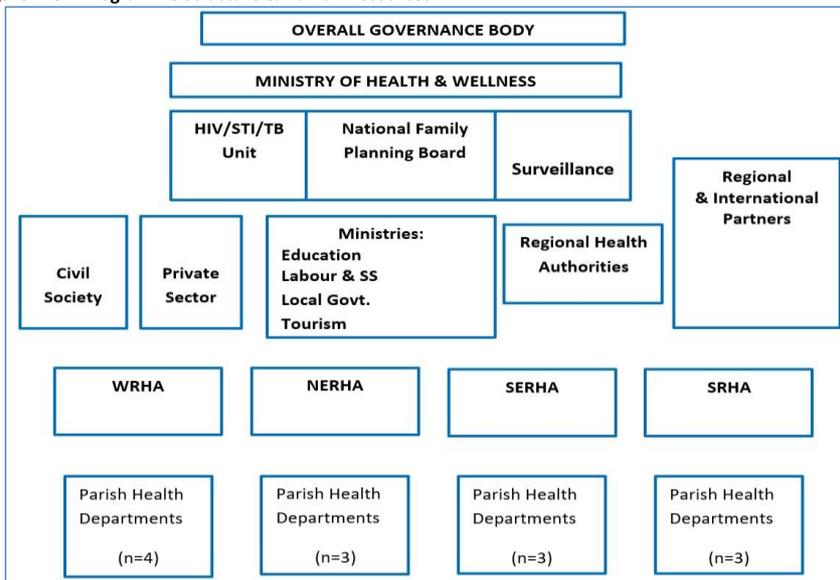
The following map shows the distribution of health centres and hospitals across the country.

Figure 2. Map of Health Centres and Hospitals

As previously discussed, HIV treatment care and support and prevention services in Jamaica are delivered in primary and secondary care facilities in the four health regions through the Public Health Clinics and Hospitals, as well as, via some CSOs that focus on KPs. Within the public sector, primary HIV services are led by the Medical Officer of Health for the parish who is supported by medical staff and public health nurses and the wider public and community health teams, while secondary HIV services fall under the Senior Medical Officers of Health for hospitals.

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[14] Adapted from Draft National Strategic Plan, A Call to Action, 2020-2025

The referral system across health services is provider-led, based on clinical assessments and in compliance with HIV clinical management protocols that include automatic referrals to other health and social welfare professionals that make up the HIV treatment team. All primary care services in the public sector are co-located within the public health clinics according to clinic type and capacity and this model is consistent throughout the country, with variations only being in staffing levels according to the size of the population each clinic serves. Therefore, more staff will be employed to the high-density regions, such as SERHA and WRHA than lower density regions. However as noted by WHO, co-location does not necessarily equal integration and from the reviewers' assessment HIV prevention, treatment, care and support although integrated into the services of the public health clinics, still operate in silos because most staff are only employed to work with HIV patients and focus on HIV testing, counselling and prevention. Additionally, because HIV patients historically have been highly stigmatised, for the sake of confidentiality the number of staff that have access to these patients is narrowed to those that are adequately trained and sensitised.

Usually, for the HIV programme and services each region has a Regional HIV Coordinator, a Regional Behaviour Change Communication (BCC) Coordinator and parish BCC Coordinators and treatment sites have Doctors, Nurses, Social Workers, Adherence Counsellors, a Case Manager, and a Psychologist with staff numbers generally apportioned according to the HIV burden in regions. Other staff may include, for example, nutritionists, and this varies from site to site. Contact Investigators who although they play a central role in contact tracing and linking PLHIV to treatment, are not specifically dedicated to the HIV programme. Per interviewed stakeholders, the absorption of HIV programme staff occurred incrementally during the past 10 years with the GoJ absorbing staff. The categories of prevention and treatment support staff that were supported for the HIV programme by the GoJ included: 1) Regional HIV Coordinators; 2) BCC Coordinators; 3) BCC Officers; 4) social workers; 5) adherence counsellors; 6) case managers; and, 7) community peer educators. Although staff operate within the GoJ human resources structures retained under a general arrangement of fixed-term contracts, which is not unlike many other MoHW staff, these staff might be particularly vulnerable to a changing workforce depending on how HIV integration is organised in the future and because, with the exception of the nutritionist post, none of the other posts, to date, have been formally established under the GoJ health staff cadres.

According to the Transition Preparedness Report, TB and PMTCT services in Jamaica are fully integrated into the primary health care. A recent list of HIV treatment sites is given as modalities differ from site to site and region to region and with most only offering HIV services on certain days. Out of the 332 health clinics in the country, HIV treatment is only offered at 49 public health clinics, which is less than 15% of facilities; however, greater coverage has been established with approximately 74% of hospitals (17 out of 23) housing HIV outpatient treatment clinics. The following listing of High Burden HIV Sites demonstrates where the top 20 HIV treatment sites are located and the other services that are available from the same location. This list typifies HIV treatment and co-located services in the higher-level public health clinics across the country.

Table 5: HIV Top 20 High Burden HIV Treatment Sites

Region	HIV sites with highest patient load	Facility type Primary (PHC) or Secondary health care (SHC)	Annual client load*	HIV service offered Prevention/ Treatment/Care & Support (p, t. c. s)	#of HIV Dedicated Staff**	STI Services Offered	RSH Offered	MNCH	TB Services ***	Other service ****	Referral Services	Referral to Where
SRHA	Mandeville Regional Hospital	SHC		p. t. c. s		Yes	Yes	Yes	Yes / diagnostic		Yes	PHC / Specialist Hospital /Private
	Mandeville Comprehensive Clinic	PHC		p. t. c. s		Yes	Yes	Yes	Yes / diagnostic /curative		Yes	
	May Pen Hospital	SHC		p. t. c. s		Yes	Yes	Yes	Yes		Yes	
	May Pen Health Centre	PHC		p. t. c. s		Yes	Yes	Yes	Yes		Yes	
	Black River Health Centre	PHC		p. t. c. s		Yes	Yes	Yes	Yes		Yes	
SERHA	St. Jago Park HC	PHC		p. t. c. s		Yes	Yes	Yes	Yes		Yes	
	Spanish Town Hospital	SHC		p. t. c. s		Yes	Yes	Yes	Yes		Yes	
	Kingston Public Hospital	SHC		p. t. c. s		Yes	Yes	Yes	Yes		Yes	
	National Chest Hospital	SHC		p. t. c. s		No	No	No	Yes		Yes	
	Comprehensive Health Centre	PHC		p. t. c. s		Yes	Yes	Yes	Yes		Yes	
	CHARES	**HIV Specialist**		p. t. c. s		Yes	No	No	Yes		Yes	
WRHA	Cornwall Regional Hospital	SHC		p. t. c. s		Yes	Yes	Yes	Yes		Yes	
	Montego Bay Type V	PHC		p. t. c. s		Yes	Yes	Yes	Yes		Yes	

	Savanna-la-mar Public General Hospital	SHC		p. t. c. s		Yes	Yes	Yes	Yes		Yes	
	Savanna-la-mar Health Centre	PHC		p. t. c. s		Yes	Yes	Yes	Yes		Yes	
	Falmouth Hospital	SHC		p. t. c. s		Yes	Yes	Yes	Yes		Yes	
NERHA	St. Ann's Bay Hospital	SHC		p. t. c. s		Yes	Yes	Yes	Yes		Yes	
	St. Ann's Bay Health Centre	PHC		p. t. c. s		Yes	Yes	Yes	Yes		Yes	
	Annotto Bay Health Centre	PHC		p. t. c. s		Yes	Yes	Yes	Yes		Yes	
	Port Maria Hospital	SHC		p. t. c. s		Yes	Yes	Yes	Yes		Yes	

*Reviewers were unable to access precise latest annual client loads per site from the MOHW, however the selection is based on the 2014-2015 site-specific treatment cascade data.[15]

** See above staff Description-Review team were not able to ascertain the exact number of staff in each position per site in a 5-day mission and were not able to access documentary evidence of this.*

*** All active TB cases are referred to National Chest Hospital for Admission in Jamaica (HIV Clinical Guidelines 2017)*

**** Other services offered at the public health centres where HIV services are offered are: *Antenatal and postnatal care*; *Child health*; *E.P.I.*; *Dental health*; *Mental health*; *Environmental health*; *Family planning*; *STI*; *Nutrition*; *Health promotion.*

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[15] Treatment Cascades, 2014-2015

Health Care Workers Integration Review Workshop (2019)

Active steps have been taken to initiate the design of an integrated primary health care service. The week after the review took place there was a workshop specifically focused on the issue of integration entitled "Full Integration of HIV Care into Primary Care Services" in consultation with a broad range of stakeholders and health workers. According to healthcare workers who were involved in the HIV Integration planning workshop, they reported that "*A culture shift is needed; outside of the concrete technical strategies we must recognize that the prevailing culture is a barrier to full integration*"[16].The key concerns, questions and recommendations that were made during the feedback sessions by health care workers on integration were:

- The importance of defining what integration means in each setting (treatment and care, prevention, diagnosis and monitoring and health information). The definition has implications for how this team will 'sell the vision' and how progress will be measured.
- Building the capacity of service providers operating in the chronic disease space/other spaces to deliver the HIV Prevention Basic Care and Treatment Basic Care Packages.
- What is needed is a transitioning of the culture that currently exists in the health system to get to the point where HIV is seen as any other chronic illness that is being managed.
- How can the systems/strategies that have been successfully utilized in HIV care be integrated into primary care?
- What are we doing from a national perspective to incorporate HIV services into the curriculum of local Health Training Institutions?
- How applicable is the Chronic Care Model to the delivery of HIV services?
- The level of care given to PLHIV should ideally be given to all chronic care patients.
- There is a systemic issue with the inputting, analysis and retrieval of data at the regional and parish levels and need to review the output from data management staff and our expectation of them and ensure the integration of information collected at the national, region and parish levels- reprioritizing is needed e.g. health centre managers must allocate and schedule time for data management daily and review of supporting supervision for data management staff.
- A culture shift – recognition that the prevailing culture is a barrier to full integration.
- The technical people need the support of the Administrators, who are ultimately accountable for implementation. This partnership between the two levels is s critical to the integration process.
- The RHAs must move away from 'project' thinking.
- A new vision or direction for the Ministry of Health and Wellness, that informs the direction of the NHP.
- Need to develop a road map based on the gaps and priorities.

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[16] Extracted from HIV/STI/TB Unit, Health Promotion & Health Protection Branch, Full Integration of HIV Care into Primary Care Services-HIV -Concern and Recommendations, page 7

4.3 AREA OF ENQUIRY: CLIENT / PATIENT / USER NEEDS AND FEEDBACK

4.3.1 Community participation

There are a number of formal ways in which key population communities participate in decision-making on HIV treatment, care and support, including as members of the JCCM, through the Greater Involvement of People Living with HIV (GIPA) that is based within the NFPB, through other CSOs and advocates, such as the Jamaican Network for Sero-positives and Equality for All, JFLAG that represents the need of the LGBTI+ community. CSO participation in the HIV response has increased

> "Civil society exists because the government doesn't fulfil all roles. The role of the government is key, but, recognize that CSOs have been born out of people's experience and passions."
> -- **Key informant**

substantially during the past decade with, for example, CSOs being active members of the CCM and holding leadership positions which has impacted greatly on the design and organization of differentiated services to meet their needs. Civil society organisations are seen as fairly well-integrated in the HIV response and valued for their ability to reach key populations not just through their own networks but according to MOHW stakeholders have been central to the success of the MOHW being able to test and link them to care.

CSOs have been providing a spectrum of prevention, treatment, care, support and services with support to from the Global Fund and PEPFAR and recently through the AIDS Healthcare Foundation (AHF), an international CSO who also has an HIV clinic in Kingston. Almost all stakeholders noted that CSOs are valued for their ability to reach key populations and are active participants in the planning and implementation of the HIV response. And, indeed, MoHW guidance is that partnerships should be developed and maintained with CSOs to enable the latter to provide support to deal with PLHIV and key populations without compromising quality or increasing risk to clients and patients. Thus, they are seen as, for the most part, integrated into the overall HIV response. Almost all stakeholders agreed therefore, there should be concentrated efforts as soon as possible to ensure that CSOs remain programmatically and financially viable so that they continue to play an important role within Jamaica's HIV response. However, none of the CSO were able to articulate a particular strategy or plans to manage this process and both CSOs and MOHW acknowledged that without external donor support, their influence might be greatly minimized. Per most stakeholders, it is expected that without substantial efforts in the near future to secure domestic resources for CSO HIV (and other health) activities, that there will be a dramatic winnowing or merging of CSOs in order for some to survive.

4.3.2 Integration advantages and disadvantage for users of HIV services

The review team was only able to interview a small group of service users. First of all, as integration could not be fully defined it was difficult for them to assess what the benefits and the drawbacks might be. However, they were of the view that HIV services are delivered by the few trained and sensitised HIV staff, but outside of this there is great deal of S&D towards PLHIV and KPS by health sector workers. Therefore, they feared that HIV service quality would be reduced if it is fully integrated for example under a primary health care model. However, they also said that they had seen vast improvements in the reduction of S&D as some of the interviewees were also involved in conducting mystery client visits and therefore they believed that with continued efforts of the part of the MOHW and JFLAG who had worked together to train staff, these issues could be overcome and in fact there was also hope that they could walk into a public health clinic in the future and not be stigmatised as HIV patients.

4.3.3 Stigma and discrimination policies

There are no policies to minimize and apply sanctions for S&D by healthcare workers or by other services users in the health sector. According to stakeholders there has been ongoing sensitisation of healthcare workers on the needs of KP and how to deliver non-discriminatory rights-based health care. The draft NSP 2020-2025 refers to the Stigma Index 2015 and Stigma in Health Facilities 2018 and

states *"Within the health sector discrimination against persons with HIV has declined considerably but some health providers and auxiliary workers in health settings breach confidentiality by gossiping about HIV patients (Stigma index survey 2015)"* The Global Fund 2019 Baseline Assessment on scaling up HIV programmes stated there are "*Current and recent initiatives around HIV-related legal services include development of redress platforms such as SIDney, which provides an integrated platform to record, analyze and exchange information on human rights violations to inform policy and programs and empower individuals and CSOs to pursue redress and …legal remedies, and JADS, which collects and investigates complaints of HIV-related discrimination across Jamaica and refers them to the appropriate entities for redress*"[17]

The reviewers were unable to make a determination about the levels of S&D in other levels of care as stakeholders perceived levels of S&D differently. For key populations, improvement in HIV services has been uneven but noting that there are a few sites where good-quality, non-stigmatising HIV care is available; though, not all key population groups shared the same experiences in interacting with the public health care system and even the civil society treatment providers where they still experienced discrimination from people at the sites, but rarely the healthcare workers but from other support staff.

4.4 AREA OF ENQUIRY: SUPPORTING RSSH INFRASTRUCTURE

4.4.1 Health Information Systems

Being able to make evidence-based decisions either at the macro-level (HIV programming), meso-level (e.g. budgeting) or at the micro-level (patient care) is based on having information and data which is valid, trustworthy, precise, reliable and timely. At all three levels, most stakeholders noted that there are opportunities for improving the health information systems.   While for Jamaica there is a National Health Information System Strengthening and e-Health Strategic Plan 2014/2018, most interviewed stakeholders noted that the various HIS continue to operate in silos and there is a strong need to integrate these systems as stated in the e-health NSP 2014/18.

The following table[18] (adapted from MOHW documentation for this report) shows that there are six existing health information systems in the health sector that are currently unlinked to HIV related information systems. In an integrated model, synergies and linkages would need to be forged to inform a holistic M&E system that captures patient data across health parameters and informs the continuum of patient centred quality care for health providers.

Table 6. Health Information systems in Jamaica

Existing Systems
1. MCSR - Used in PHC, aggregate, manual
2. HMSR- Used in SHC, aggregate, manual
3. Mental Health-aggregate, manual- not relevant to HIV
4. Morb-base - case based medical record case abstract- created from discharge summaries
5. PAS- Legacy standalone electronic system. Implemented 20 yrs. in 11 health facilities, costly; to be phased out
6. GNU Health/Epas - Piloted in 12 facilities but is currently limited by legacy PAS implementation at some sites

For HIV, these systems include an HIV Electronic Register which includes an HIV/AIDS Treatment Database (HATS) and PMTCT Database that are operational at all treatment sites. However, treatment

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[17] Baseline Assessment - Jamaica Scaling up Programs to Reduce Human Rights Related Barriers to HIV Services, the Global Fund September 2019 Geneva, Switzerland
[18] Extracted from HIV/STI/TB Unit, Health Promotion & Health Protection Branch, Full Integration of HIV Care into Primary Care Services- HIV Heath Information Action Plan, page 25

data from the private sector is not currently captured nor does the electronic monitoring system for ARV drugs involve all public and private pharmacies across all parishes. Similarly, the District Health Information System 2 (DHIS2) was introduced to link the databases across all treatment sites with the intent to track and manage patients who sought care at multiple sites and collate data for national analysis and reporting using Unique Identifier Code for PLHIVs.   The review team was not provided information as to whether this DHIS2 system has been fully implemented.

However, some of the issues raised by stakeholders included data accessibility, the need to develop or improve standard operating procedures (SOPs) and having multiple reporting lines. These include the Monthly Clinic Summary Reporting system (MCSR), the Hospital Monthly Summary Report System (HMRS, the Mental Health Aggregate, Morb-base, the Patient Administration System (PAS) and GNU Health electronic PAS (pilot). At the service delivery level, a few stakeholders noted the need to strengthen the patient record system both in terms of moving from being primarily paper-based to electronic and then linking that into the national system.

Currently tools, processes, and guidance do not exist that would allow joint monitoring of cross-disease progress and stakeholders noted a need to renew efforts to eliminate parallel reporting systems. Therefore, to monitor an effective integrated HIV programme this would be a major undertaking that would need to be resolved. According to the MOHW in their program continuation request to the Global Fund in 2018 they plan to in the current phase of the grant to "*Improve health information systems, data collection procedures and quality assurance and control measures to strengthen cascade analysis for KP and yield analysis… [d]evelop… a National E-Health Enterprise Architecture which will define data, information and security standards and support interoperability of various E-Health solutions*"[19]

For both PSCM and labs the National Health Information System Strengthening and e-Health Strategic Plan 2014/2018 calls for the implementation of an inventory management and pharmacy information system, as well as, logistics information system for public laboratories; though, the review team was not able to assess if these systems had been fully developed or implemented.

4.4.2   Procurement and supply chain management

Data insufficiency was a particular challenge in assessing procurement and supply chain management, therefore, the review team was unable to undertake a full analysis of this area of the programme. However, the following discussion might be informative to integration considerations and planning.

Interviewed stakeholders consider, both the procurement and lab systems to be further along in terms of integration. Antiretrovirals (ARVs) and other health products are procured using the government's pharmaceutical procurement and distribution system, The National Health Fund (NHF), an agency of the MoHW which was established in 2003 by the National Health Fund Act. Part of its mandate is to assist Jamaicans to access medication in both the public and private health sectors and deliver in-patient and outpatient pharmacy services for the public health sector. As such, ARV procurement and other HIV related medical supplies such as condoms are fully integrated into the national system.

4.4.3   Health and HIV financing

Data insufficiency was a particular challenge in assessing health and HIV financing, therefore the review team was unable to undertake a full analysis of this area of the programme. However, the following discussion might be informative to integration considerations and planning.

The following table outlines the source of funds for 2018/2019 period:

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[19] Global Fund, Jamaica Continuation Request 2018.

Commented [CG1]: TO EHG: is this comprehensive? Is this the total budget for health?

This is linked to the ToR question: what are the sources of funds fo rhte health system?

A key question from the ToR that is not answered is the following; are HIV services part of a common benefit package or are they considered in practice separately outside of a package of basic services?

Commented [AB2R1]: Yes, it is comprehensive-the total budget according to the source.

HIV services are part of a common benefit package

Commented [TC3R1]: Sentence added in paragraph below.

MINISTRY OF HEALTH REVENUE ESTIMATES 2018/2019 For the Financial Year Ending 31st March 2019 (USD)	
Registration of Pharmacies and Pharmacists	480,000.00
Registration of Drugs	36,000,000.00
Parents Contribution toward Maintenance of Children in Children's Home	18,000,000.00
Drug Permits	600,000.00
Miscellaneous Receipts	1,200,000.00 12
Advisory Panel on Ethics	216,000.00 0.00
TOTAL- MINISTRY OF HEALTH	**56,496,000.00**
INSTITUTIONAL PROJECTS AND PROGRAMMES	
Transitional Funding Mechanism (TFM	315,385.0
Support to the National HIV/AIDS Response in Jamaica	623,999.0
Programme for Reduction of Maternal and Child Mortality (PROMAC)	256,722.0
HIV Prevalence in Most-at-Risk Population Reduced (USAID)	361,582.0
Institutional Strengthening to Improve National Surveillance, Prevention and Control of Infectious Diseases	15,000.0
Strengthening of Health Systems	26,040.0
Total Health	**1,598,728.0**

Costing of Jamaica's HIV response was included into the country's multi-year budget plans with HIV having its own line items and commitments; though, it should be noted that it is part of the common benefit package.

The Jamaica two-year budget for 2015-2016 states *"… achieving sustainability of national HIV program interventions at adequate scope and scale will require substantial increase in financial commitment from the Government of Jamaica for HIV response in upcoming years[20]."* Contributions by the GoJ in 2016 were estimated at 38% which represented an increase of approximately 83% compared to 2015[21] with the GoJ committing to financing: 1) human resources; 2) the use of health care facilities; and, 3) ARVs, reagents, and test kits (which are already integrated into the existing pharmaceutical procurement and distribution system via the National Health Fund).

However, Jamaica's high debt payments (estimated at 56% of the national budget) are a strain on health sector spending and leaves very little fiscal space to scale up HIV programming[22]. Given the limited fiscal space for health, improving the efficiency and equity of public health expenditures is important.

4.4.4 Laboratories and laboratory networks

Overall funding for lab services has decreased, because of previous successes, per stakeholders, they have continued to make progress on integration of their services including developing field-testing, quality assurance and drug resistance protocols, and the lab information system. Currently, they are working with twenty-six sites to increase electronic access and, thus, reduce turn-around times for patients and developing their overall capacity in order to monitor for potential side effects. Further, the treatment and care programmes screen people during their outreach efforts and then, if needed, send the person for further testing such that the potential patient is integrated into a package of care.

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[20] Jamaica Budget 2015-2016; Ministry of Health
[21] Ibid
[22] Revised National HIV Policy 2017, Jamaica FIRST DRAFT (Prepared for the National Family Planning Board)

4.5 Key Incentives for integration

The reviewers found in interviews with stakeholders and in documents (TPA, World Bank Report[23], PEPFAR Sustainability Index[24], PEPFAR Regional Operational Plan[25]) that there were a number of incentives to fully integrate HIV services. They have been broadly categorized under three main themes, with different levels of priority of afforded to each theme according to stakeholder type. They are:

1) **Change In external funding landscape:** From the government's perspective the main driver of integration is the recognition that the external funding scope for the HIV programme is changing given Jamaica's World Bank classification as an upper-middle income country and non-eligibility for international aid. Therefore, the need for cost savings and allocative efficiencies are critical for the health sector in the future in maintaining the current level of the HIV response. PEPFAR recently diverted funds from the MOHW to civil society organisations which according to some stakeholders was unexpected and also created some level of urgency to fully rationalize an integrated HIV programme, project the likely costs and how it will function practically in a resource limited setting. The World Bank Report on Jamaica highlighted the lack of integrated health system financing and organisation and the need for "… improved … efficiency through redistribution of health workers…" as fundamental issues for the health sector. It also stated that "efficiency through redistribution of health workers may also impact equity, as the lengthy wait times may drive the poor to seek care at private facilities, where wait times are shorter."[26] These two points are particularly critical for charting a pathway to integration by carefully assessing human resource needs and efficiency and service user accessibility.

2) **Increasing uptake of HIV treatment services (and improving health outcomes and targets):** HIV programme staff and EDPs on the other hand are mainly driven by the desire to achieve greater health outcomes for PLHIV and meet UNAIDS 90-90-90 and elimination targets by 2030 and to also develop a healthcare system that meets international standards in line with WHO's UHC and leaving no one behind initiatives. Therefore, adopting integrated models of healthcare would expand the reach of the HIV response to systematically untapped areas of health care, such as family planning and maternal child health, where a critical mass of women, for example, could be targeted for HIV diagnosis and treatment and improve ARV coverage.

3) **Reducing stigma and discrimination**: CSO are primarily driven by a desire to make HIV services more accessible and less stigmatized for the key populations that they serve. According to some stakeholders, an integrated model that removes vertical/disease specific-clinics would reduce stigma when accessing services for PLHIV and promote greater utilization and retention in care.

4.6 Key Barriers and Risks for Integration

The reviewers also found a number of potential barriers and risks to integrate HIV services. These include:

1. **Cost savings:** Cost savings and allocative efficiencies is an incentive for the GOJ, it is also a potential barrier to achieving an integrated health care system and for achieving UHC for all. The WHO review of public spending report for Jamaica in 2017 stated *that "universal health coverage is difficult* [to achieve] *when total public spending is less than 4-5 percent of GDP…* and…*the Pan American Health Organization…indicate*[s] *that public health expenditure of 6 percent of GDP is a useful benchmark for countries in the region aiming to attain universal health coverage, which is above Jamaica's spending levels…"*

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[23] Jamaica Review of Public Health Expenditures, World Bank July 19, 2017
[24] 2016 Sustainability Index and Dashboard Summary: Jamaica, PEPFAR
[25] Regional Operational Plan 2019, Caribbean Regional Program Strategic Direction Summary
[26] Jamaica Review of Public Health Expenditures, World Bank July 19, 2017

The government's health expenditure has averaged 3.5 percent over the past 20 years. HIV/AIDS has been declared as a priority by the Government, but to assure adequate transition towards sustainability of HIV national response, the declaration is to be substantiated with credible funding allocations from the State and with legislative amendments. The National Integrated Strategic Plan (NISP) 2020-2025 that is costed and is accompanied with M&E plan needs to be approved by a government resolution to ensure that NISP has more legal power to drive adequate allocations within the national budget and remove some of the structural barriers that prevent the effective control of the epidemic, particularly as they relate to laws criminalizing KP groups.

2. **Election cycles:** EDPs and civil society stakeholders in interviews also expressed concerns that there is a tendency of successive governments to prioritise short-terms wins and not necessarily tackle larger more complex issues, such as health sector reform that are long-term goals, given the four to five-year electoral cycle. They also cited past efforts as there had been several that failed to achieve the desire results.

3. **Stakeholder skepticism:** There was a significant degree of skepticism among all the stakeholders, including MOHW staff about the future success of integration efforts. Many stakeholders expressed both reservation and exasperation within the integration discussions as part of this review as they noted that "integration" has been a well-discussed topic both within Jamaica and the LAC region. The failure to facilitate the seamless integration of HIV into SRH to improve efficiencies and scale-up and the subsequent detrimental impact on the HIV programme was frequently referred to as a significant disappointment. Many expressed concerns that this review may not lead to any actions and some key informants frankly informed the team that the review was a waste of time.

4. **Stigma and discrimination:** The significant level of stigma and discrimination against key populations, including in some cases criminalization has raised concerns about the feasibility of providing good quality HIV services for key populations (KPs) in primary care facilities. Currently, CSO organizations play a critical role in reaching key populations. While HIV treatment and care services are

> "Integration needs to be done cautiously in order not to lose the gains the vertical response has made with key populations."
> -- **Key informant**

funded for the most part by the Government of Jamaica (GoJ), HIV prevention and enabling environment activities receive a notable amount of donor funding and have not been absorbed by the GOJ in a significant way, although MOHW stakeholders acknowledge that their capacity to reach KP has relied heavily on the work of the CSOs. If HIV programmes are not carefully examined prior to integration and inclusive of the needs of the end-users, the participation of civil society and key populations in decision-making may be significantly reduced and their willingness to access future services will decrease. As external development partners have exited from countries it has been already shown that civil society organisations, in general, have tended to either disappear or have merged in order to survive. HIV services are currently delivered at the public health facilities but most stakeholders agreed bottlenecks included lack of sufficient training, stigma and discrimination toward PLHIV and KPs. While the NFPB is working with CSOs to train and sensitise healthcare workers in the primary and secondary care facilities, there is no guarantee that these efforts will be successful due to high staff turnover (i.e. the need to repeat trainings) and, in some cases, an entrenched bias, including stigma and discrimination, towards key populations. Therefore, a system-wide reorientation of staff would be required to adequately prepare for a primary health care approach, moving away from the current vertical programme approach. It has been recommended in some documentation, that all health care workers should undergo minimum ethics and/or human rights training including confidentiality guidelines.

5. **Non-standardisation of services:** A few stakeholders noted that the decentralisation of authorities for service provision to the Regional Health Authorities (RHAs) was challenging as this set up a system in which the four RHAs had high coordination burdens amongst themselves and some were of the view that this had contributed to the non-standardisation of services in general and fragmentation.

6. **Lack of guidance on integration models and best practices**: Key informants also said that there was currently a lack of information to guide them on deciding on which models of care could be applied within a limited resource setting and that UNAIDS was in the process of commissioning an 'Investment Case' for Jamaica.

7. **Human resources shortages**: Human resources for health (HRH) has been and continues to be a primary constraint for the integration of HIV programming. As noted in Jamaica's "Vision for Health 2030-Health Sector, there is a severe shortage of human resources for health (HRH). HRH shortages are aggravated by high staff turnover and attrition, and the introduction of a "no-user fee" policy resulted in increased demand for health services in the public sector, which further exacerbated the challenge. Specific to HIV, between 2004 and 2012, more than 18,000 PLHIV were linked to care, and the healthcare work force did not increase proportionately. The Transition Preparedness report referred to a 2014 Human Resource Analysis for HIV Services study carried out by Tomblin et al[27] that revealed that overall the full time equivalent (FTE) of currently deployed health care workers in the field is 62% of the optimal level required, with the largest gap in the number of support staff. Evidence points to the gap between current and optimal levels of health care workers widening in the next five years as a result of high patient load. However, the Revised National HIV Policy 2017 acknowledges that the patient ratios for the HIV response are still above the average ratio for that within the general health care system. Thus, many stakeholders expressed concerns that integrating the HIV programme into a poorly resourced health system is a significant risk. PEPFAR's sustainability index also concluded, "With respect to human resources for health it is noted that a significant proportion of the staff providing HIV services are not fully institutionalized… [and] sustainability of the response is fragile"

8. **Weak M&E and access to data**: The institutional arrangements that govern service delivery are challenged by poor reporting requirements, performance targets set on an ad hoc basis, and a lack of action for noncompliance with reporting or missed targets. Three-year Service Level Agreements (SLAs) between the MOHW and the RHAs are reviewed and updated annually but are not utilized to their full potential. Weaknesses in these institutional arrangements impact the ability of the MOHW to make decisions or allocate resources on the basis of need and performance and respond to health issues as they emerge. Further, capacities are limited by lack of resources and training, including building space from which to operate.

9. **Antipathy between health programmes and services:** Finally, a central theme of the interviews that emerged as a particular challenge to integration was that historically there has been a significant resentment towards the relatively well-funded HIV programme, given that other areas of the health service have been poorly resourced. This resentment is further aggravated by talks of integration and additional responsibilities that are perceived as shifting the burden on already over-burdened health care workers at a time when the funding is coming to an end and when they do not consider that they benefitted from the programme or were recognized for their contributions to the success of the HIV programme. Therefore, MOHW staff say that health care workers would see very few incentives to expand their roles to deliver HIV services that they have not traditionally been responsible for.

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[27] Tomblin Murphy G., MacKenzie, A., Guy-Walker, J., & Walker, C. (2014). (Needs-based human resources for health planning in Jamaica: using simulation modelling to inform policy options for pharmacists in the public sector. Human Resources for Health, 12, 67. http://doi.org/10.1186/1478-4491-12-67)

5 OPTIONS

The reviewers propose the following options for consideration for HIV integration: These options are based on previous models as articulated by the WHO.[28]

Integration Options

OPTION 1 [29]	ADVANTAGES	DISADVANTAGES
Model: Patient Centred Team Based Primary Care Horizontal case management approach-team members assigned to patients according to need in consultation with patient and caregivers How to achieve it? Establishing an integrated governance framework Led by laws/ policy and operational guidance/directives Instituting new and amending existing protocols Reconfiguring health teams Training/reorienting/skilling up staff/ Task shifting Establishing an integrated health information/reporting system	Well established that patient centred care improves the quality of health care, reduces costs and improves patients' clinical outcomes (WHO) Minimises traditional boundaries/territories that exist within the healthcare system. Patient-centred care can be employed by primary care teams in any specialty and is effective across disease types. Improved patient provider relationship, satisfaction Increases efficient use of diagnostic testing, prescriptions, hospitalizations, and referrals. Promotes preventative care and patient ownership/involvement in their care Allows involvement of community teams/CSO/differentiated care approach/Social contracting Reorients staff to patient centred health care delivery partnering in decisions about their own care/responsibilities Flexible/dynamic approach with staff/teams' makeup according to needs Reduces stigma and discrimination by removing HIV-specific sites (and services)	Requires substantial investment to reform health sector delivery Major reform of health governance structures & organisation/staff structures/policies and procedures/Requires major Health System Strengthening Accommodates MOHW direction for case management approach Requires increased staff cadres/staff to deliver approach Extensive training of staff and reorientation of organisational culture Risk loss of specialism that vertical approach offers/reduced quality of care HIV program target focus might be diminished in system wide approach
OPTION 2[30]	ADVANTAGES	DISADVANTAGES
Model: Vertical–Horizontal Synergy Model Maintain vertical disease specific service delivery programmes but ensure horizontal integration across services via referrals for a patient centred holistic approach to health care. How to achieve it? Led by policy and operational guidance/directives Instituting new and amending existing protocols/	Less costly than Patient Centred Team Based Primary Care Model Minimal reform of health governance structures & organisation/staff structures Maintenance of disease specific technical expertise Maintain quality of vertical programmes Minimal upheaval of current service delivery arrangements Minimal need to recruit/increase staff cadres Minimal disruption to service users and patient provider relationships	General health services are weakly developed when vertical disease specific approaches are applied which affects ability for vertical programmes to reach their targets (WHO) Health System strengthening might not have the same urgency Status quo might be maintained with no improved efficiencies (e.g. long waiting times) Staff need to be trained/might be resistant to training and task

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[28] The reviewers acknowledge that NSP 2020-2025 in accordance with Vision 2019-2030 are positioning an integrated HIV programme within a primary health care model.
[29] High Level Policy Brief-Accelerating UHC: Ending Epidemics of HIV, TB, Malaria and other Communicable Diseases, through Integrated People- Centred Health Service, WHO/ADGO/CDS/Global Fund

[30] WHO (https://www.who.int/bulletin/volumes/83/4/editorial10405/en/)

Training/reorienting/skilling up staff/ Task shifting Developing referral pathways Expanding/integrating health information/reporting systems	Ability to maximise relational health status between provider and patient to engage in discussions about other health needs and health screening Broadens skill set across health sector/maximises the efficiencies of current staff Expands surveillance and M&E/facilitates cross sharing of information sharing/enhances strategic Information CSO and Private sector providers can contribute more to vertical programmes	shifting/HR/Labour laws considerations /consultations Staff overburden/lack of motivation Less scope for cost efficiencies might Services might still be stigmatised
OPTION 3[31]	**ADVANTAGES**	**DISADVANTAGES**
Model: Integrated SRH Model (HIV/FP/MCC) at Service Delivery Points (SDP) Strategic sites (SDPS for integrated service delivery of HIV/FP/MCC) How to achieve it? Led by policy and operational guidance/directives Instituting new and amending existing protocols/ Training/reorienting/skilling up staff/ Task shifting Developing referral pathways Expanding/integrating health information systems	Less costly than Patient Centred Team Based Primary Care Model & Vertical Horizontal Models Brings synergies across select programmes targeting reproductive age-group at strategically located SDPs (PEPFAR, 2013) Accommodates NFPB/MOHW integration focus Maintains focus of FP/MCC and HIV Takes a broader approach to SRH and is not disease specific Results in a horizontal approach to service delivery Flexible/integrations can take place at HIV SDPs or FP SDPs (PEPFAR 2013) Holistic SRH approach to PLHIV/broadens disease/treatment focus Offers more support to PLHIV Expands HIV response/prevention/testing to SRH/FP service users Reduces stigma and discrimination	Narrower focus on SRH/ignores wider health of person Excludes person not in reproductive age range Risks loss of HIV focus Might result in the exclusion/loss of KP focus (Traditionally female oriented) Staff need to be trained in use of new protocols/&HIV/MCC & FP-might be resistant to training and task shifting/HR/Labour laws considerations Staff overburden/lack of motivation

It might also be useful to consider a combination of the options at different service delivery sites based on capacity, need, patient load and assessed cost of implementation.

6 CONCLUSIONS AND NEXT STEPS

Despite previous efforts regarding the integration of HIV programming, there are still several fundamental issues which need to be addressed such that Jamaican stakeholders can take advantage of potential opportunities, overcome barriers, and ultimately move toward its goal of universal health coverage without sacrificing any gains which have been made in HIV programmes. First and foremost, there needs to be a discussion about reaching a shared definition of "integration" and what that implies for the various levels at which integration might occur and what is possible given the limited fiscal space and rooted mentality of healthcare workers. Though, the NSP for HIV/STI 2020-2025 proposes a PHC-based approach to HIV service delivery, the document is notably still in draft.

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[31]Monitoring the Integration of Family Planning and HIV Services; Freyder et al, Measure Evaluation 2016

The implication of strengthening integration and facilitating a patient's ability to navigate the health care system is that the supporting health systems infrastructure must, likewise, be in place for healthcare providers and their clients with the goal of improving access to early diagnosis, quality treatment and retention in care, especially for key populations to close some of the gaps in the treatment cascade. However, prior to any integrative and/or health systems strengthening efforts, there must be a clear vision as to how health services, including HIV, should be delivered. The responsibility for articulating this vision is clearly within the MoHW's and the GoJ's purview. For example, the MoHW/GoJ might choose to focus on delivering health services via a patient-centered and team-based primary health care model which would focus on a horizontal case management approach with team members assigned to patients according to need and in consultation with patient and caregivers. Similarly, health services could be provided in a vertical–horizontal synergy model in which vertical disease specific service delivery programmes are maintained, but, horizontal integration occurs across services for a patient-centered holistic approach to health care.

Most recently, as outlined in the previous NSP the idea was put forward to deliver HIV in an integrated sexual and reproductive health model at service delivery points which would offer integrated service delivery of HIV, family planning, and maternal and child health. There might also be the scope to combine elements of each option according to different service delivery sites based on capacity, need and patient load. Some of these ideas may have been discussed at the recent workshop "Full Integration of HIV Care into Primary Care Services. Thus, the options as presented are only initial steps because they are predicated on a clear and endorsed vision by the GoJ/MoHW of how health services can and should be delivered.

While the political commitment which Jamaica has shown toward integration is commendable, unless there is a shared understanding among stakeholders about the current status of integration (e.g. to what extent HIV services are integrated), then additional discussions become challenging. Further, these discussions need to be based on the realities of what is possible within the Jamaican healthcare system and, perhaps, more importantly, within the current and future domestic funding environment. Again, stakeholder opinions vary regarding these two important elements. However, it is believed with sufficient political leadership and vision these issues can be resolved and some of the options outlined in the following section, can be given serious consideration and the country can decide upon an appropriate integration model going forward.

The MOHW in partnership with the key stakeholders should consider the report findings and models of integration proposed for Jamaica. Key steps to integration include:
1. As assessment of the primary health care installed capacity
2. An assessment of the geographic distribution of the burden and key populations
3. Mapping of HIV services by level of complexity, and identifying the gaps
4. Planning how to fill gaps in terms of human resource and equipment needs
5. Defining option(s) chosen for integration and how they will contribute to improving the efficiency of health services and expanding coverage
6. Costing of various options through investment case studies and organisational capacity assessments.
7. Developing a feasible roadmap for the incremental integration of HIV programming.

ANNEX 1: TERMS OF REFERENCE

REVIEW:
INTEGRATION OF HIV SERVICES IN THE LAC REGION

BACKGROUND

Latin America and the Caribbean (LAC) countries have committed, through the Sustainable Development Goals (SDGs) adopted in 2015, to end preventable child deaths, end the epidemics of AIDS, tuberculosis and malaria, and achieve universal health coverage. Those goals are expected to be met in a context of changing epidemiological profile of many infectious diseases, the rise of non-communicable diseases, an increasing number of health security threats as well as expectations for already burdened systems to deliver higher-quality care and a broader package of health services to respond to people's needs.

Overall, integrated service delivery at the point of care has been suggested as one way to improve efficiency and expand coverage. The Global Fund's Strategy 2017-2022 "*Investing to End Epidemics*" recognises that disease-specific programmes, including HIV, tuberculosis and malaria, must be integrated into platforms for integrated service delivery, such for example, an antenatal care or integrated community case management organised around the health needs of the population and social expectations.

Specifically, on HIV and the Latin America Region, available analyses on the sustainability of the HIV response identify the need to advance in integrating national HIV programmes within the broader national health system to achieve ambitious HIV goals, sustain and scale up coverage of priority interventions and spread costs associated with controlling the epidemic.

Overcoming the disease-specific structures and thinking and ensuring that the disease-control programmes are embedded within the existing health system, pose considerable challenges to policy makers and implementers wishing to embark on integrated HIV control. Integrated service delivery requires a shift across the health system – from the way services are organised and delivered at the facility-level to the way national disease programmes are planned, funded and implemented at the national level. The practice of integrating services comes also with associated risks and difficulties in implementation1. For example, in the case of the HIV response, the significant level of stigma and discrimination against key populations in the LAC region, where most countries have concentrated epidemics, as well as the weak capacity of the primary care level in some countries have raised concerns about the feasibility of providing good quality HIV services for key populations in primary care units. Another risk is that by removing vertical HIV programmes, the participation of civil society and key population in decision making processes is expected to significantly reduced/disappear. Understanding those concerns and the capacity of the countries to addressing them is necessary to determine the feasibility of promoting further integration of the HIV response.

In order to continue supporting countries to implement sustainable HIV responses while contributing to UHC, and looking ahead to the next Global Fund allocation and consecutive round of funding request, this review to be conducted in two different countries in the Latin America and the Caribbean region (Jamaica and Dominican Republic) aims to strengthen the knowledge and stimulate thinking both at country level and at GF Secretariat level, about key challenges and solutions for countries to advance in the implementation of efficient integrated HIV programmes.

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[1]Some of these challenges mentioned in the literature include, the fact that restructuring may cause resentment among managers, in some cases leading to obstruction and other difficulties in managing the process; or the need for substantial training. Staff at all levels will need to acquire new knowledge about the additional diseases they are now meant to control, and about the collection and interpretation of data to monitor and evaluate their integrated programmes.

Objectives

General objective:
The main objective of this thematic review is to better understand the current status of integration and identify bottlenecks that prevent further integration of national HIV programmes in the Jamaica and Dominican Republic health systems.

The proposed review will generate information and evidence that is expected to be used by the countries' stakeholders, Global Fund and partners to inform the planning and implementation of integration efforts (including potential requests for funding from the Global Fund and other donors), with the final aim of supporting the countries to improve health outcomes and service outcomes (coverage, efficiency, etc.).

Specific objectives:
Specifically, the review is aimed at:
   a) Assessing the level of integration of HIV programme in the rest of the health system in terms of governance, financing, management system and service delivery in Jamaica and Dominican Republic;
   b) Identifying bottlenecks at different levels of the system in these countries to operationalise integration, including cross-programme integration of policies, planning, processes, institutional capacity and health financing;
   c) Identifying opportunities for incremental integration, ensuring key principles of the HIV response (i.e. participation of people affected by the disease) are retained;
   d) Facilitating country discussion and supporting the countries in the design of a feasible roadmap for incremental integration (*scope to be confirmed based on the assessment*);
   e) Providing recommendations to the GF LAC team on how GF can support integration in order to contribute to more sustainable responses.

I. Scope of Work
Geographic scope: For this review, the two selected countries are Jamaica and Dominican Republic.

The current thematic review will provide a comprehensive analysis of the current country context, identifying and documenting options, progresses, challenges and solutions in the planning and implementation of integrating HIV programmes in the specific country health system. In this analysis the consultant/s is/are expected to collect meaningful information on the different dimensions and levels of integration (governance, service delivery, health management systems and financing) of the HIV programme for each country and, if relevant, propose recommendations and strategies for further integration.

Integration can be understood in multiple ways. According to the most recent WHO definition, integrated health services are health services that are managed and delivered so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services, at different levels and sites of care within the general health system and according to their needs throughout their life course.

Supporting integrated health services does not mean that everything must be integrated into one package nor necessarily delivered in one place. It does mean that services must be arranged so that they are not disjointed and are easy for the user to navigate. This, in turn, means that providers must have management support systems (e.g., procurement and supply chain systems, health information systems, financial management systems, etc.) in place to foster integration and make the best use of resources. For that reason, this review is expected not only to analyse the level of integration in *service delivery* (arrangement of a defined package of health services for each level of care and a functional referral system) but also the situation at multiple levels, specifically: *governance*

(coordination of strategic and operational planning across the disease-specific programmes); *financing and health systems management* (functional alignment of systems, including PSM, HMIS, HRH and laboratory systems). Finally, in order to support adequate planning and implementation, the analysis also collects information about the level of current political commitment on HIV programme integration.

The assessment should be guided by the vision of improving health outcomes and service outcomes (coverage, efficiency, etc.). While covering all the areas listed above, the assessment should be designed and implemented ensuring that it clearly explains how improvements on those areas will result in outcomes in terms of the effective coverage, readiness, availability and utilisation of key HIV services (prevention, testing and treatment), with focus on key populations; acceptability of services especially by most vulnerable populations, quality and efficiency of HIV services and the continuum of care.

The assessment should be based on a solid reference framework, build on the experiences and lessons learnt through the multiple assessments implemented globally by technical and funding partners including WHO2, USAID or PEPFAR (as an example, see below the Results Framework for the Integration Principle3). The selected reference framework should be clearly explained in the technical proposal and used to define the methodology and structure the reports.
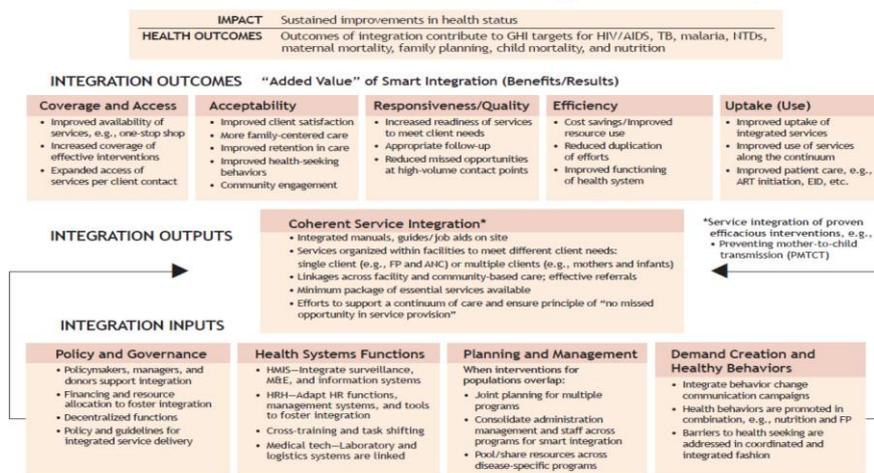
The analysis is expected to address the list of questions below, however, please note that it is not an exhaustive list of questions and should be expanded as deemed appropriate by the team to adequately cover the objective of this thematic review in the inception report, considering the specific context of each country.

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[2] WHO/HIS/HGF/HFGuidance/17.2, A System-Wide Approach to Analysing Efficiency across Health Programmes / Susan Sparkes, Antonio Durán, Joseph Kutzin (Health Financing Guidance No 2)
[3] Global Health Initiative (2012), GHI Principle Paper on Integration in the Health Sector.

1. Political commitment

This section is expected to deliver an assessment of the political will and commitment from stakeholders at different levels of the health system to merge/ coordinate HIV-specific systems and processes.

1. Has the concept of integration (in general and not particularly for HIV) been formally endorsed by the health sector? How? What does it look in practice (i.e. policies, planning mechanisms, etc.)? Is there a strategy for implementation?

2. To what extent do senior government officials and other senior health planners, programmatic partners and external funders demonstrate leadership, show commitment to and / or understand the benefits of HIV integration? / What evidence or examples are there of stakeholders demonstrating political will or making commitments to integration? Which stakeholders were these, at what level? What kind of integration were they referring to?

3. Do the National Strategic Plans (NSPs) for HIV refer to integration? If so, how this is defined?

4. Has the country made efforts to support integration of HIV in the past? Which dimension or services? How successful was this and why?

5. If done, how is the Government incentivising integration of HIV? (joint planning, guidelines, supervision and monitoring, financing, etc.)

6. What are the main political drivers of integration? For example, is integration being championed by particular institutions and individuals? Is it mostly driven in response to a particular opportunity or necessity (i.e. integration as a means to extend services to underserved areas)?

7. How do country stakeholders perceive the role of external donors, particularly TGF for supporting the integration agenda?

8. What have been the main political barriers to integration?

2. Governance (structure & planning)
9. How is the Ministry of Health organised (Organigram)?

10. What is the capacity of the MoH to steer and manage across the different programmes/ services (regulation, planning, monitoring)?

11. How is the HIV programme organised? (separate unit? with other units, or other?) (please include references to the implementing units of the main donors). In the case of an on-going reform, how is the HIV programme visualised within the health structure?

12. Is there a coordinating authority covering HIV? What diseases/sectors?

13. How are programmes, in general, coordinated in terms of planning? At what level and how do programme and health system plans come together?

14. What are the accountability mechanisms to enable results in each programme? How are these mechanisms used? Are these mechanisms different from the rest of the health system?

15. Is HIV integrated in another disease/condition plan (joint planning)? How?

16. What are the advantages and disadvantages of a HIV joint planning with other conditions?

17. What could be the opportunities for integration of HIV programme in the health governance structure?

18. Does the country have formal ways (outside of the HIV area) for communities to participate in decisions that affect how their care is designed, organised and delivered?

19. Is there policy in place to avoid/ minimise stigma and discrimination in the health sector? How it is enforced?

3. Service delivery

20. What is the structure of health service delivery? How it is organised and how many levels of care are available at country level?

21. Where are health and HIV services delivered? At what level of care? How is that care coordinated with other services? Is there horizontal (across type of services) or vertical coordination (across levels of care)?

22. If integrated health services have been implemented in the country: what were the criteria for integration? Why were those services integrated and not others? Which were the steps of integration processes? What have been the main benefits and challenges? Is there a good model as a recommendation of integration of specific programmes?

23. What kind of specific HIV services are delivered? Who is in charge of delivering specific HIV services? (vertical trained staff, all staff at service delivery point, other) and where (patients diagnosed and managed at PHC unit, special health facilities or units in second level of care, only complicated cases are referred to special units, etc.)?

24. How are those services interrelated (are the same organisations and managers responsible for all categories of HIV services)?

25. Are HIV outreach services integrated with other health services? How? How are HIV outreach services linked with facility-based health care (including health centers as well as HIV clinics)?

26. Describe the link between public and private health service delivery. Are there referral systems from primary to secondary/tertiary care?

27. Are HIV services coordinated with other health services (STI, TB, etc.), including if any additional services is provided by the same provider along with HIV services? How? (one-stop shop, co-location of services, referral system, other)

28. Are there services/areas that particularly target the same audience as the HIV services?

29. What would be the main bottlenecks if HIV services were delivered at primary health care units?

30. If integration of ART treatment was to happen, to what extent will S&D against PLHIV and KP from the health providers be a major barrier? What is the evidence available on S&D against PLHIV and key populations by health care providers in general services and in HIV specific services? What are the programmes in place to reduce levels of S&D? To what extent is S&D preventing integration of HIV services in other levels of care?) Is it a barrier that can be surmounted in the medium term (3-5 years)?

4. Health Management Systems (HIS, PSM, Human Resources)
Health Information Systems and M&E

31. How many information systems are there in the government health sector? Who enters the information at what level? How are the systems financed? Does HIV programme have its own information system? What areas does it cover?

32. Does the HIV Monitoring and Evaluation process align with other programmes? Is it more effective? What are HIV M&E risks in case of integration? Is supervision, training and monitoring of HIV priority services in line with integrated approach (one monitoring checklist, one trained team for several diseases, field visit together and with coordinated approach)?

33. Health Information System for HIV:
    a) Are there separate reporting and information tools (please briefly describe)?;
    b) Do tools, processes and guidance exist that would allow joint monitoring of cross-disease progress and efforts to eliminate parallel systems;
    c) Is there cross-disease HIS and joint disease surveillance system at all levels, joint progress indicators (particularly for HIV-TB)
34. Please describe if and how the Global Fund information demands (performance framework indicators) are integrated into the national health information system.

Laboratory services:
35. How is the National laboratory network organised?

36. Is the lab connected to the information system? Are the results available for clinicians and decision makers?

37. Where do laboratory diagnostics for HIV and HIVDR take place? Where are viral load and CD4 count performed?

38. Are there different labs for different interventions/tests/programmes? If yes, what are they? How do they coordinate?
39. What are the opportunities for more integrated approaches?

Procurement and Supply Chain
40. Who is responsible for procurement of medicines and supplies?

41. What are the systems to procure medicines and supplies? How are they financed? How many supply chains are there?

42. Are HIV medicines, supplies, tests procured by the general system? Is HIV supply chain coordination in place? Is there coordination between HIV supply chain and that of different programmes? At what levels?

43. If HIV procurement and supply chain is separate and was to be integrated, are there major problems in the procurement of health products by the country that would negatively affect the availability of HIV drugs?

Human Resources for Health
44. What is the Health workers density by cadres?

45. What are the various cadres of health workers? By health programme? What services do these cadres provide? Where do they provide services? What sources of funding pay for these cadres?

46. What is the availability of health workforce at PHC facilities to provide additional services (staffing pattern: severe shortage; adequate education and training, etc.)?

47. Are community health workers formalised in the health system trained on prevention, screening, referral of suspected cases and follow up of diagnosed cases (for: MNCH, NCDs, Communicable diseases, malnutrition, etc.)?

48. Health cadres for HIV services: who is delivering what? Would providers of HIV services be open to provide a broader range of services? What would be their motivations/concerns?

49. Are HIV cadre's payment aligned with others health workers? Are there different financial incentives between HIV Services and the health system?

50. If HIV services were to be further integrated, what changes in human resources would be required?

5. Financing (budget, payment, etc.)

51. What are the sources of funds for the health system/health services? Do some programmes have specific, distinct sources? Do any programmes have their own revenue collection arrangement?

52. How are budgets determined across programmes? What information is used to determine priorities and allocations? How are programmes coordinated with one other in terms of planning and budgeting? Does the public financial management system allow for coordination? How do allocations flow through the system?

53. What accountability and reporting mechanisms are in place?

54. What are the sources of funds for the HIV response? Does it have specific, distinct sources (for example, taxes on specific consumer goods)?

55. How is HIV included in the budget? (separate budget line for HIV; for communicable diseases, other)? Are funds for all inputs needed to provide the services pooled separately, or are specific line items merged?

56. How are resources divided between different programmatic areas and how much comes from different sources (Government and donors)?

57. Are different HIV services paid by different budget lines?

58. Is external funding for HIV included in the national budget? How?

59. Are HIV services part of the common benefit package or are they considered in practice separately outside of a package of basic services?

60. Resource tracking for HIV or for health (and HIV within the health resource tracking mechanism)

61. Are there incentives for providers with respect to deliver services? Are there any incentives for providers to deliver services on HIV?

6. Summary of analyses

1. For each country, identify what could be integrated and how (recommended integration model/s). Described pros, cons and key risks to be mitigated for the different options.

2. Identified challenges for integration and recommended strategies and approaches to influence critical levers within the health system to allow for better delivery of integrated health services and to catalyse system-wide changes.

3. Based on the recommendations, include good practices at the global level on the integration of HIV national programme in the broader health system that could be relevant with the selected countries as a reference.

4. Recommendations for optimising Global Fund investments to support cost-effective integration.

Methodology
This review will include a mixed method approach involving two key components: a) desk review of relevant guidelines, programme reports, and past assessments; and b) Key informant interviews and focused group discussions with key personnel at country level and at the Global Fund.

The organisation should propose the methodology. The following approaches are meant to provide a general guidance:

1. Desk review
The desk review will include review of key published global literature on integration as well as main country documents, including national health and HIV strategies, programme reports and past assessments.
The desk review should include epidemiological and programmatic data available to form the basis for the analysis of the need and expected outcomes.

2. Field visit
It is expected that the review team, in consultation with the Global Fund teams, would develop within the selected countries, criteria for stakeholders and activities (group or individual meetings, visits) to be included in the review. The meetings should include managers, providers and beneficiaries to have a complete picture from both demand and supply perspective.

3. Interviews of key people at the Global Fund
The Provider will work closely with the Global Fund relevant staff during both phases namely with the Country teams/Public health and M&E specialists/S&T specialists. They will provide guidance, inputs and feedback into the framework and methodology, facilitate the introductions and the coordination to and with local partners' in-country. The Country teams will also monitor the implementation of the review.

3b. Interviews / involvement of key partners in countries
With the guidance of the country team, this thematic review will be done in coordination with the national HIV programme, and relevant in-country partners in each of the selected countries. This is important to ensure local needs are met and appropriate access is granted to the programmes. They should continue to be involved and updated as appropriate throughout the process.

4. Dialogue in country
It is expected that consultant will conduct a second country visit to share the analysis of potential opportunities for the integration of services and facilitate discussion in country for the identification and validation of strategies and interventions for incremental integration of HIV services

EXPECTED TIME AND LOE REQUIRED: (TAILOR TO COUNTRY SPECIFIC NEEDS)

- The whole process for this review is expected to take up to 30 working days per country, depending on how the service provider will organise its team and itinerary.
- Time Period: The review is expected to be conducted (including final report) from July – October 2019.
- The Service Provider should have the ability to work in English and Spanish languages.

DELIVERABLES
1. Inception report:
The study framework and detailed methodology including timeline for the review, starting with Jamaica (1 week)
The consultants should describe in detail the framework for conducting the assessment and analysis, including methods and tools to collect and analyse the information through different sources, the definition of integration to be used and the approach taken to conduct the thematic review.
2. Report of the assessment:
Draft report to be submitted to the Global Fund country team. Upon their review, if deemed satisfactory, the draft report will be shared with the country stakeholders for their comments. The organisation may be requested to review the draft and work in a revised version if country team assesses that significant changes need to be done before sharing it with the country.
Draft report for Dominican Republic should be submitted both in Spanish and English Languages.
Draft report for Jamaica should be submitted in English.

3. Final report with actionable recommendations:
• Final report for each country (to be agreed) and summary report (to be agreed) with actionable recommendations, incorporating the finding from the desk reviews and field visits and based on the discussions in country on the strategies and interventions for incremental integration of HIV response in the health sector.

• User-friendly summary document (1-3 pages)

• Presentation: up to 20 neat slides summarising key findings and recommendations

• Documents on Dominican Republic should be submitted both in Spanish and English.

• Documents on Jamaica should be submitted in English.

ANNEX 2: REVIEW MATRIX

Area of Inquiry	Questions	Data Collection and Sources of Information / Evidence	Data Analysis
1. **Political Commitment**	**Primary Questions:** 1. Has the concept of healthcare services integration been formally endorsed by the health sector? What does it look in practice (i.e. what is the extent via evidence by which government officials and other relevant health sector partners demonstrate their commitments)? Who and/or what are the main political drivers and barriers to integration? 2. What is the capacity of the MoH to steer and manage across the different programmes/ services? 3. How is the HIV program currently organized and visualized within the health structure? Is there a coordinating authority for HIV? If so, what are its linkages with other coordinating bodies? **Secondary Questions:** 1. Which stakeholders at which levels have committed to integration? 2. Are there currently any incentives (political or otherwise) to integrate HIV services? 3. Do the National Strategic Plans (NSPs) for HIV refer to integration? If so, how this is defined? 4. What have been the main political barriers to integration?	**Desk review:** • Review of National Strategic Plans for HIV • Review of health sector strategic plans • Ministry of Health organograms • Mapping of health sector coordinating bodies • Review of any relevant evaluations of health programs **Key informant interviews** • GF Secretariat staff / Country Teams • MOHs senior leadership • MoH programmatic directors • Other relevant government counterparts (e.g. national health insurance, social security, Ministry of Finance, etc.) • CCM members, PRs • Relevant external development partners • Relevant civil society organizations • Subset of HIV service providers (those providing a high volume of services)	• Structured content analysis of documents and literature • Analysis of stakeholder experiences and opinions • Context Analysis • Triangulation between different sources of information
2. **Client / patient / user needs and feedback**	**Primary Questions:** 1. Does the country have formal ways for communities to participate in decisions that affect how their care is designed, organized and delivered? 2. What do end-users of HIV services see as the main benefits and drawbacks to HIV service integration? **Secondary Questions:**	**Desk review:** • Review of existing and available documents related the status of civil society and key affected populations • Review of any policies and/or legislation related to stigma and discrimination • Relevant transition plans / assessments	• Analysis of documents and literature • Analysis of stakeholder experiences and opinions (civil society organizations and end-users of HIV services) • Triangulation between different sources of information and among respondents /informants

	1. Is there policy in place to avoid/minimize stigma and discrimination in the health sector? How it is enforced? 2. To what extent is S&D preventing integration of HIV services in other levels of care? Is it a barrier that can be surmounted in the medium term (3-5 years)? 3. How do country stakeholders perceive the role of external donors, particularly TGF for supporting the integration agenda? 4. What plans are in place for civil society / key affected populations to maintain their participation in HIV services decision-making as external donor support is reduced? 5. If integration of ART was to happen, to what extent will S&D against PLHIV and KP from the health providers be a major barrier?	• Other relevant documents (National strategies, etc.) **Key informant interviews:** • Civil society leaders • Key affected populations / end-users of HIV services • Civil society CCM members • Human rights commission members	
3. **Delivery of health services (HIV and other services)**	**Primary Questions:** 1. Where are health and HIV services currently delivered? How is that care coordinated with other services? What are the referral systems between services? 2. What would be the main bottlenecks if HIV services were delivered at primary health care units? Would providers of HIV services be open to provide a broader range of services? If HIV services were to be further integrated, what changes in human resources would be required? **Secondary Questions:** 1. If integrated health services have been implemented, what were the steps of integration processes? 2. What kind of specific HIV services are delivered? Who is in charge of delivering specific HIV services? 3. How are HIV services coordinated with other health services (STI, TB, etc.), including if any additional services are provided by the same provider along with HIV services? 4. Are there incentives for providers with respect to deliver services? Are there any incentives for providers to deliver services for HIV?	**Desk review:** • Review of existing and available documents related to the delivery of HIV and other health services • Other relevant documents (e.g. national health sector strategies, National Strategic Plans for HIV, etc.) • Reviews and evaluations of health programs **Key informant interviews:** • MOH senior leadership • MoH programmatic leads Healthcare service providers (both HIV and primary health care)	• Content analysis of documents and literature through application of a desk review tool • Analysis of stakeholder opinions • Triangulation between different sources of information
4. **Supporting RSSH Infrastructure**	**Primary Questions:** 1. How many information systems are there in the government health sector (e.g. does the HIV program have its own information system)?	**Desk review:** • Review of National Strategic Plans for HIV • Review of health sector strategic plans • Ministry of Health organograms	• Content analysis of documents and literature • Analysis of stakeholder feedback

2. What are the procurement and supply chain systems in country? How integrated are they? 3. What are the sources of funds for the health system/health services? How are programs coordinated with one other in terms of planning and budgeting? Are HIV services part of a common benefit package or are they considered in practice separately outside of a package of basic services? **Secondary Questions:** 1. Is HIV integrated in another disease/condition plan (joint planning)? How? 2. At what level and how do programme and health system plans come together? 3. What are the advantages and disadvantages of a HIV joint planning with other conditions? 4. What could be the opportunities for integration of HIV program in the health governance structure? 5. Do HIV Monitoring and Evaluation processes align with other programs? What are HIV M&E risks in case of integration? 6. Do tools, processes and guidance exist that would allow joint monitoring of cross-disease progress and efforts to eliminate parallel systems; 7. How is the National laboratory network organized? Where do laboratory diagnostics for HIV take place? 8. If HIV procurement and supply chain is separate and was to be integrated, are there major problems in the procurement of health products by the country that would negatively affect the availability of HIV drugs? 9. What are the sources of funds for the health system/health services? Do some programs have specific, distinct sources? Do any programs have their own revenue collection arrangement? 10. How are budgets determined across programs? What information is used to determine priorities and allocations?	• Review of any relevant evaluations of health programs • National health account budgets (if accessible and available) **Key informant interviews** • GF Secretariat staff / Country Teams • MOHs senior leadership • MoH programmatic directors • Other relevant government counterparts (e.g. national health insurance, social security, Ministry of Finance, etc.) • Relevant external development partners	• Triangulation between different sources of information

ANNEX 3: INDIVIDUALS INTERVIEWED

Ministry of Health and Wellness
1) Dunstan E. Bryan, Permanent Secretary
2) Dr Naydene Williams, Director, Health Services Planning and Integration
3) Dr. Melody Ennis, Head, Family Health Unit
4) Dr Nicola Skyers, Director, National HIV/STI Programme
5) Dr. Beverley Wright, Director, Health Systems Support and Monitoring Unit
6) Dr. Michelle Hamilton, Director of Immunology, National Public Health Laboratory

South East Regional Health Authority
1) Dr. Chambers, Regional Technical Director, South East Regional Health Authority
2) Dr. Audene Garrison, Internal Medicine/Infectious Diseases Consultant, Kingston Public Hospital
3) Dr. Dianne Campbell Stennett, Regional Technical Director, Western Regional Health Authority

Government of Jamaica
1) Lovette Byfield, Execute Director, National Family Planning Board
2) Denese McFarlane, Health Specialist, Planning Institute of Jamaica

Civil Society Organisations
1) Anonymous – two HIV clinical service users
2) Dr. Carolyn Gomes, Co-Chair of the Sustainability Sub-Committee for the National Strategic Plan
3) Dr. Kevin Harvey, Caribbean Regional Director, AIDS Healthcare Foundation
4) Yolanda Paul, Vice Chair, Jamaica Country Coordinating Mechanism
5) Jaevion Nelson, Executive Director, Equality for All Jamaica-J-FLAG

Development Partners
1) Bernadette Theodore-Gandi, Country Representative, PAHO
2) Dr. Suzanne Robinson Davis, Consultant, PAHO
3) Casimiro Canha Cavaco Dias, Health Systems and Services Advisor, PAHO
4) Althea Spence, Project Management Specialist, USAID
5) Sacha Hill-Lindo, PEPFAR M&E Specialist, USAID
6) Victoria Nibarger, Caribbean Regional Program Coordinator, PEPFAR
7) Manoela Manova, Country Director, UNAIDS
8) Ruben Pages, Community Support Advisor, UNAIDS
9) Erva Jean Stevens, Strategic Information Advisor, UNAIDS
10) Varough Deyde, Director, CDC Caribbean Regional Office

Global Fund Secretariat
1) Olga Bornemisza, Senior Advisor, Resilient and Sustainable Systems for Health
2) Erin Ferenchick, Consultant, Resilient and Sustainable Systems for Health
3) Carmen Gonzalez, Sustainability and Transition Specialist, Latin America and the Caribbean
4) Lillian Pedrosa, Fund Portfolio Manager, Latin America and the Caribbean
5) Yira Tavarez Villaman, Public Health and M&E Specialist, Latin America and the Caribbean

ANNEX 4: DOCUMENTS REVIEWED

1. A System-Wide Approach to Analysing Efficiency Across Health Programmes, WHO, 2017

2. Building Resilient and Sustainable Systems for Health, The Global Fund, 2019

3. Caribbean Regional Strategic Framework on HIV and AIDS, CARICOM/PANCAP, 2014

4. Framework on integrated people-centred health services, World Health Organization, 2016

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

6. Handing Over Health: Experiences with Global Fund Transitions and Sustainability Planning in Serbia, Thailand and South Africa, ICASO, 2016

7. High Level Policy Brief-Accelerating UHC: Ending Epidemics of HIV, TB, Malaria and other Communicable Diseases, through Integrated People- Centred Health Service, WHO/ADGO/CDS/Global Fund

8. HIV Epidemiological Profile, Ministry of Health/Jamaica, 2016

9. Integrating the HIV response at the systems level: experience of four countries in transition, Health Finance & Governance Project, Abt Associates, 2018

10. Jamaica: HIV/AIDS Program Transition from Donor Support Transition Preparedness Assessment, Country report, CIF

11. Jamaica Key Populations (KP) Services Framework, 2016

12. Jamaica: Review of Public Health Expenditures, The World Bank, 2017

13. Mid-term Evaluation: Jamaica's National Integrated Strategic Plan for Sexual and Reproductive Health & HIV 2014-2019, Condell Consulting, 2017

14. National Family Planning Act, Government of Jamaica, 1970

15. National Health Information System Strengthening and e-Health Strategic Plan 2014/2018, October 2013

16. National Integrated Strategic Plan for Sexual and Reproductive Health & HIV 2014 – 2019, Jamaica

17. Performance Frameworks and Summary Budgets for the Principal Recipients of the Global Fund grants in Jamaica, 2019

18. Program Continuation Request, Jamaica, 2018

19. Projected Transitions from Global Fund support by 2025 – projections by component, the Global Fund, 2018

20. The Public Procurement Act, 2015, Government of Jamaica

21. Rapid Assessment of the Jamaica Key Populations Challenge Fund (KPCF) Stigma-reduction Training, Palladium, Health Policy Plus, 2016

22. Referral and Linkage Protocol for HIV-2014, National HIV/STI Programme, Ministry of Health Jamaica and Clinton Health Access Initiative;

23. Regional Operational Plan Caribbean Regional Program Strategic Direction Summary, PEPFAR, 2019

24. Revised National HIV Policy 2017, Jamaica FIRST DRAFT (Prepared for the National Family Planning Board)

25. Transition Preparedness Assessment Report (in DRAFT)

26. Sustainability Index and Dashboard Summary: Jamaica, PEPFAR, 2017

27. Vision for Health 2030: Ten Year Strategic Plan 2019-2030, Ministry of Health and Wellness/Jamaica