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NATIONAL PLAN OF ACTION FOR
ORPHANS
& OTHER CHILDREN MADE VULNERABLE BY
HIV/AIDS
IN JAMAICA

2003 - 2006

CHILD DEVELOPMENT AGENCY, MINISTRY OF HEALTH

NATIONAL PLAN OF ACTION FOR
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Acknowledgement

The impact of the AIDS epidemic has been felt the hardest among children. The problems faced by children begin long before their parents die. The economic pressures on families increase as parents fall sick, children begin to experience the fear of losing their parents and growing uncertainty about the future, they drop out of school, face stigma and discrimination and at the end, are often left with little or no family or community support.

The development of this National Plan of Action for Orphans and Other Children made Vulnerable by HIV /AIDS (OVC) is aimed at providing a protective environment in Jamaica for those children whose well-being and development have been impacted by the disease.

The National Steering Committee on Orphans and Other Children made Vulnerable by HIV / AIDS would like to thank all of those persons who contributed to the development of the Plan.

This document was made possible by the dedicated time and effort of many individuals. A special thank you is due to the initial 50 volunteers who built the structure on which the Plan was refined and the 200 participants at regional consultations that added the body. Your time and dedication were exemplary.

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Winston Bowen
Chairman
National Steering Committee on Orphans
and Other Children Made Vulnerable by HIV/AIDS
Jamaica, October 2003

For every child
Health, Education, Equality, Protection
ADVANCE HUMANITY



Glossary of Terms

ASO - AIDS Service Organisations

BCC - Behaviour Change Communication

CBO - Community-Based Organisations

CCC - Caribbean Council of Churches

CDA - Child Development Agency, Ministry of Health

**CHARES - Centre for HIV/AIDS Research, Education and Services,
University Hospital of the West Indies**

CI - Contact Investigator

CMO - Chief Medical Officer

FBO - Faith-Based Organisation

JAS - Jamaica AIDS Support

JNHCP - Jamaica National HIV/AIDS Control Programme

JN+ - Jamaica Network of Seropositives

MOV - Means of Verification

NAC - National AIDS Committee

NAP - National HIV/AIDS Prevention Programme, Ministry of Health

NGO - Non-Governmental Organisation

NPC - National Planning Council

**OVC - Orphans and other Children made Vulnerable
by HIV/AIDS**

OVI - Objectively Verifiable Indicators

PAA - Parish AIDS Associations

PHA - Parish Health Authorities

PLWHA - Persons Living With HIV/AIDS

RHA - Regional Health Authorities

STI - Sexually Transmitted Infections

UN - United Nations

UNICEF - United Nations Children's Fund

UWI HARP - University of the West Indies

HIV/AIDS Response Programme

**VCCT - Voluntary Confidential Counselling
and Testing**



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Introduction

This document represents the National Plan of Action for Orphans and Other Children Made Vulnerable by HIV/AIDS in Jamaica, 2003-2006. It is designed to support the Jamaica HIV/AIDS/STI National Strategic Plan, 2002-2006 (JHANSF), respond to the needs of the National Plan of Action for Children, and address pressing issues for improving the quality of life for orphans and other children made vulnerable by HIV/AIDS (OVC) in Jamaica. Background on the status of the AIDS epidemic in the region and in Jamaica, as well as the status of the national response, is amply documented in the National Strategic Plan. As such, this document focuses on issues facing OVC and their caregivers in Jamaica, mindful of the cultural, social, economic and infrastructural realities.

Orphans and Other Children Made Vulnerable By HIV/AIDS: Global Perspectives and Agreements

The United Nations Children's Fund (UNICEF) reports that globally, by 2001, AIDS had killed the mother or both parents of 13.4 million children then still under the age of 15. UNICEF estimates that by 2010, the total number of children orphaned by AIDS will increase to 25.3 million. As the epidemic worsens in the Caribbean, UNICEF also notes, the number of orphaned children in the Caribbean will increase dramatically.

UNICEF has identified eight key characteristics of the profound impact AIDS has on the lives of affected children.

- 1) **Children suffer profoundly as their parents fall sick or die.** Their experience is often characterised by:
- 2) **Psychological distress.** Their parents' illness and death causes extreme psycho-social distress - worsened by the pervasive stigma and shame attached to HIV/AIDS.
- 3) **Economic hardship.** With parents unable to work and savings spent on care, children are forced to take on frightening adult responsibilities of supporting the family.
- 4) **Withdrawal from school.** The pressures of earning for and caring for parents and siblings can lead children to withdraw from school, even while their parents are living. The pressures to abandon schooling intensify when one or both parents die.
- 5) **Malnutrition and illness.** Orphans and other affected children are more likely to be malnourished or to fall ill - and less likely to get the medical care they need. Poverty is the root cause, but neglect and discrimination by adults in whose care they have been left are also important factors.
- 6) **Loss of inheritance.** Orphans are regularly cheated out of their inheritance.
- 7) **Fear and isolation.** Dispossessed orphans are often forced out to unfamiliar and hostile places.

- 8) **Increased abuse and increased risk of HIV.** Impoverished and without parents to educate and protect them, orphans and affected children face every kind of abuse and risk, including HIV infection. Many are forced into exploitative and dangerous work - including exchanging sex for money, food, “protection” or shelter.

In June 2001, the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) issued a Declaration of Commitment that included a special section on children orphaned and affected by HIV/AIDS. The Declaration states categorically that member states should:

Paragraph 65. By 2003 develop and by 2005 implement national policies and strategies to:

- build and strengthen governmental, family and community capacities to provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS including appropriate counselling and psycho-social support;
- ensure their enrolment in school and access to shelter, good nutrition, health and social services on an equal basis with other children;
- protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance;

Paragraph 66. Ensure non-discrimination and full and equal enjoyment of all human rights through the promotion of an active and visible policy of de-stigmatisation of children orphaned and made vulnerable by HIV/AIDS;

Paragraph 67. Urge the international community, particularly donor countries, civil society, as well as the private sector to...support programmes for children orphaned or made vulnerable by HIV/AIDS in affected regions, in countries at high risk and to direct special assistance to sub-Saharan Africa.

The UNGASS commitments were revisited by the UN a year later in **A World Fit for Children**, where a Declaration was produced that included a review of progress to date and a plan of action. This Declaration was adopted by the General Assembly 10 May, 2002. The Assembly resolved to “take urgent and aggressive action as agreed at the special session on the General Assembly on HIV/AIDS” and elected to place particular emphasis on three of the agreed goals and commitments. Paragraph 65, cited above, was one of those three.

The World Fit for Children Declaration continues with specific strategies and actions for the implementation of this goal, identified in paragraphs 47(1) to 47(8). In 47(8) the Caribbean is identified as a focus for increased international development assistance to halt and reverse the spread of the epidemic and to mitigate its impact on children. Also pertinent to this Plan of Action is the 1989 Convention on the Rights of the Child, which lays out the human rights of children world-wide. The Plan of Action is also in consonance with the 1996 International Guidelines on HIV and Human Rights, which again singles out children as a particularly vulnerable group in need of tailored attention.

This Plan of Action is fully in accord, both in word and in spirit, with all of these international agreements, understandings and plans of action.









The Jamaican Response



UNICEF has played an important role in developing a framework for effective programming for adolescents in Jamaica. This is evidenced, for example, in its 1999 publication *Changing the Future for Jamaica's Children*, which had as its expressed intention to “help solidify the Country Programme strategy of disseminating essential information on Jamaican children that can be effectively transformed into action-oriented knowledge, not only by children themselves, but also within the larger social policy community in Jamaica” (p. 1). Indeed, many of the issues raised in that document came up again in the course of the development of this Plan; for example, increasing resources and basic social services for children, improving the quality of social sector information, community-based services for children with disabilities, and decentralisation and community empowerment.

In May 2001, UNICEF hosted a workshop in Jamaica for Latin America and the Caribbean entitled “Orphans and Children in Families Made Vulnerable by HIV/AIDS.” Out of this came a series of initiatives that led to the production of the current National Plan of Action. Jamaica is the first country in the Caribbean to focus on this critical area in addressing the epidemic. In addition, prior to the development of this Plan of Action, the Jamaica HIV/AIDS National Strategic Plan, 2002-2006 (JHANSP) had set a goal of improving the socio-economic well-being of the people of Jamaica, and had identified the number of children orphaned by HIV/AIDS as an indicator of its success.




By May 2002, Jamaican consultant Hope Ramsay and external consultant Mark Loudon were contracted by the National AIDS Committee, with funding from the United Nations Children's Fund, to undertake a Rapid Assessment of the Situation of Orphans and Other Children Living in Households Affected by HIV/AIDS in Jamaica. Both consultants have considerable expertise in addressing the needs of OVC.

The Assessment confirmed many of the findings identified by UNICEF. In summary,

-  Too many children are in trouble (school absenteeism, street children, crime, abuse, abandonment, suicide, drug abuse, early pregnancy, depression, etc.).
-  Extended families are finding it more difficult to absorb extra children (poverty, already caring for “shifted” children, stigma of HIV/AIDS).
-  HIV-positive mothers have an average of 4 children who will need alternative care when they die; fathers play a limited role in providing homes for these children.
-  Stigma is often propagated in schools, clinics and children's homes by people who should know better.
-  Many Jamaicans are willing to foster children who are not related to them - especially if they are helped financially.
-  Children respond well to counselling and mentoring - people in positions of influence (teachers, nurses, pastors, etc.) should be educated on HIV and trained in counselling.
-  Social services should be made more accessible and “user friendly” so that more people use them - this will save money and improve lives, in the long run.
-  No organisation is big enough to tackle this problem alone - it needs partnerships and co-ordinated action.

-  More broad-based research is needed to understand the scale and nature of the predicament in which children and caregivers find themselves.
-  A participatory situation analysis could bring together all the role players to pool their insights and ideas and develop a National Plan of Action, and to establish a co-ordinating structure.

The consultants also found that community health workers and NGOs are deeply worried about:

-  the number of adults already living secretly with HIV;
-  the incidence of child abandonment, sexual abuse, violence, exploitation and crime; and
-  the number of Jamaicans who are not able to access the services that are supposed to be available to them.

At current estimated infection rates (1.5% in the general adult population), the Assessment determined that between 10,000 and 20,000 children are already at risk of losing one or both parents to AIDS. Further,

“ the “average lifetime risk” of dying from AIDS is believed to be anywhere between three and five times higher than HIV prevalence in a given country. This means that, without aggressive intervention to curtail the epidemic and to keep those already infected alive, many more Jamaican children could live through the horror of watching one or both parents die, and of facing a very uncertain future. (p. 2) ”

The Assessment also recommended seven concrete actions that have been incorporated into this Plan of Action.









How This Plan Was Produced

The National Plan of Action was produced through a participatory planning process, as recommended in the Assessment. After a series of workshops held around the country to sensitise stakeholders to the issues of orphans and other children made vulnerable by HIV/AIDS (OVC), the Child Development Agency at the Ministry of Health, with the assistance of the National AIDS Committee and funding from UNICEF, brought on board a local consultant to participate in a two-day workshop with already sensitised participants from around the country (or their designated representatives) to develop the material that would feed into the National Plan of Action.

The starting point for the national consultation workshop was the Rapid Assessment of the Situation of Orphans and Other Children Living in Households Affected by HIV/AIDS in Jamaica. The recommendations for action made in that document formed the basis of the workshop's discussions.

The First Draft of the National Plan of Action was a result of that work. Since then, the Plan has been workshoped at each of the four Health Regions, in consultation with stakeholders there. Further consideration and streamlining of the ideas coming out of these workshops, have been incorporated to produce the National Plan for Orphans and Other Children Made Vulnerable by HIV/AIDS in Jamaica, 2003 - 2006.

Produced using the participatory planning approach, the Plan is fully in keeping with the JHANSF, in that it recognises in its design and intent each of the guiding principles of the JHANSF:

-  HIV/AIDS is a developmental issue, not just a health problem, and, as such, is a national priority.
-  HIV/AIDS must be normalised so that it becomes a part of the customary public discourse.
-  The rights and dignity of every individual, including those who are socially marginalised, must be recognised.
-  The response must be multi-dimensional and multi-sectoral.
-  People living with HIV/AIDS (PLWHA) must be involved in the national response.
-  Individuals and communities must be empowered to prevent the spread of HIV.
-  Prevention and care are synergistic components of one strategy: each dependent upon and enhanced by the success of the other.
-  Policies should be formulated on the basis that transmission of HIV is preventable through the understanding of the nature of the epidemic.

The Plan is also in conformity with stated priority areas for the JHANSF:

1. Policy, advocacy, legal and human rights
2. Integrated and multi-sectoral response
3. Prevention
4. Care, treatment and support

Each of these areas is addressed in the Plan of Action. The Plan of Action is also in conformity with the stated purpose of the JHANSP, to mitigate the socio-economic and health impact of HIV/AIDS in society. Indeed, the Plan addresses key indicators identified at the goal and purpose level of the JHANSP, including the number of AIDS orphans, the mortality rate from AIDS, and median survival of PLWHA.

The Plan of Action also complements the outputs of the JHANSP in relation to orphans and other children made vulnerable by HIV/AIDS by

- incorporating an effective multi-sectoral response to the HIV/AIDS epidemic;
- incorporating, as a critical component, strategies to reduce individual vulnerability to HIV infection by promoting a range of behavioural changes within the target population;
- incorporating strategies to reduce transmission of HIV infection; and
- incorporating, as its core, a Plan of Action designed to improve care, support and treatment services for PLWHA, HIV-positive children, and children affected by HIV and AIDS.

The Plan of Action also contributes to the effective implementation of the JHANSP in providing a comprehensive care and support framework for orphans and vulnerable children among our youth, epidemiologically established as one of our highest risk groups nationally, and for youth infected and affected by HIV/AIDS at the community, regional and national levels.

The Purpose of the National Plan of Action

With the agreement of the Child Development Agency of the Ministry of Health, UNICEF, the National AIDS Committee, and the National Steering Committee on OVC, the intention is that this Plan of Action will be used as a template for work plans at the regional and parish levels, under the auspices of the Child Development Agency of the Ministry of Health, in collaboration with partner agencies and institutions, some of which were identified at the regional consultations. At the regional and parish levels, research will have to be conducted to identify more detailed needs, as well as the services and partner institutions to meet them. These will include such things as the need for food, for home-based care, for housing in places of safety, for school fees, and so on. This Plan was thus developed as a guide for the preparation of work plans and not as a detailed work plan, itself.

Summary of the Plan of Action

The Plan of Action has, as its foundation, revisions of the key original recommendations produced by the Assessment and agreed to at the regional consultations and by the National Steering Committee on OVC.

The Vision agreed to at the regional fora is:

An efficient and effective participatory network established and operational at the community level, sustained by community, national and international resources, to enhance the quality of life for orphans and other children made vulnerable by the HIV/AIDS epidemic in Jamaica.

The Mission agreed to at the regional fora is:

To ensure that all categories of caregivers in society and all key institutions—particularly health, education, child correctional services, social security and the Child Development Agency—are educated, sensitised, and equipped to respond to special issues surrounding orphans and other children made vulnerable by HIV/AIDS, in order to make services and service providers accessible at the community level.

The Plan incorporates six key outputs that were identified by the stakeholders as critical elements in improving the quality of life for orphans and other children made vulnerable by HIV/AIDS. These are to:

I: Strengthen the capacity of families and institutions to care for OVC.

Families that can continue to care for OVC need to be provided with the necessary tools to do so. In many instances, micro-loans, advice and support in parenting skills, stress management, and other capacity-building activities can prove sufficient to allow families to manage life with OVC. Similarly, caregivers at institutions need information, skills training, and support in caring for OVC. The Plan seeks to mitigate the impact of HIV on OVC by strengthening the capacity of existing caregivers.

II: Disseminate information on, and facilitate access to, existing social services.

Many citizens are not aware of existing programmes that offer support to the public. Further, many of our citizens do not know what their entitlements are, or how to access these programmes and services. Many services are also not user-friendly for OVC and their caregivers. The Plan calls for action to increase public awareness of services and service user skills.

III: Provide psycho-social support to caregivers and orphans and other children made vulnerable by HIV/AIDS.

Psycho-social support is one of the most effective ways in which the quality of life for OVC and their caregivers can be enhanced. The Plan calls for a range of community leaders and gatekeepers, such as teachers, the police and clerics, to be sensitised to the psycho-social issues confronting OVC and PLWHA, as one way of increasing community understanding of the epidemic. The aim of this output is to provide psycho-social support at the community, as well as at the parish and regional levels.

IV: Reduce stigma and discrimination against PLWHA and those associated with them.

The Plan proposes a broad and comprehensive public sensitisation campaign, along with focused community interventions aimed at dispelling myths and reducing stigma and discrimination. The Plan also calls for the active involvement of PLWHA in these interventions at all levels. A broad range of interventions is envisaged as central to the effectiveness of this component.

V: Co-ordinate information on issues faced by OVC and share this information with relevant agencies.

An expressed need by the stakeholders is for the co-ordination and dissemination of information about OVC. The Plan calls for an OVC Focal Point to report such information to the National

Steering Committee on OVC, who will then disseminate information to the relevant organisations involved in providing services to OVC and their caregivers. The Focal Point will also be responsible for overseeing the implementation of work plans approved by the National Steering Committee on OVC.

VI: Advocate for provision of medical therapies that prolong the life of caregivers of OVC, since healthy parents result in fewer orphans.

The Plan contends that increased access to anti-retrovirals and treatment for opportunistic infections in a non-discriminatory environment is a cornerstone to reducing both the number and vulnerability of OVC in Jamaica, as it reduces the mortality rate of caregivers. As such, it advocates for universal access to life-saving medication for caregivers of OVC.

The full Plan of Action is presented in tabular form on page 16.

Issues in Implementation

There are important barriers to the success of the project. These need to be confronted as the process moves forward. For example, gender and power relationships, as they play out in family dynamics, must be understood as issues related to OVC and must be addressed in this context. This includes how decisions are made regarding condom use during sex.

The activity that calls for behaviour change communications (BCC) interventions promoting age-appropriate messages for OVC is also critical, as the vulnerability of OVC extends to their own risk behaviour.

Further, the level of prejudice at the community, parish, regional and other levels needs to be understood. In many instances, health care and other public service workers contribute to the marginalisation of PLWHA, OVC and their caregivers. Teachers have been reported to contribute to the stigmatisation of students in schools, where children associated with PLWHA have been publicly identified and ridiculed. Some families experience community pressure against accepting PLWHA or OVC into their homes.

Another major technical constraint is staffing. Existing staff are already stretched to—and in some cases beyond—their limits. Social workers, for example, and contact investigators already face formidable workloads. While in many cases sensitisation of existing staff will be key to effective implementation, the reality that additional staffing will be required was identified by many people throughout the Plan's development.

Although the constraints faced in operationalising this Plan of Action are quite real, they can be addressed through effective collaboration among governmental, non-governmental and private sector organisations and community groups. UNICEF has expressed its support, but the sustainability of the project is still an issue. As currently envisaged, an OVC Focal Point at the Ministerial level will need to be appointed to manage the project at the national level, under the supervision of the National Steering Committee on OVC.

The Child Development Agency personnel at the parish level will form an integral part of the management of the project at regional and parish levels. The ground has therefore been laid, through the participatory planning process, for an effective collaboration between government and civil society to manage this project. At the regional consultations, private sector partnerships that could be effective at the community level were already being discussed and individual companies identified.

Other important resources have also been identified. For example, the Assessment found that many individuals are prepared to absorb OVC into their families but need assistance to do so. The Plan attempts to minimise the amount of new financial resources necessary by drawing, wherever possible, on existing programmes to support such families. Child shifting, a staple of Jamaican society, thus works to the advantage of the project.

If the potential of these partnerships to support OVC and their caregivers is realised, it will go a long way to easing some of the critical factors driving the epidemic. These include stigma and discrimination, poverty, denial and isolation, and lack of information. The project thus presents a unique opportunity to forge a synergy across sectors that builds on existing work, such as work with schools, the clergy, and the police force, as well as the general public. This will require strong collaboration with several Ministries, including the Ministries for education, labour, social security, local government and national security.

A strength of the Plan is its advocacy for a public sensitisation campaign co-ordinated by participants at all levels. Thus, the campaign, as envisaged, could operate in individual schools simultaneously with mass media campaigns already on stream through the BCC programme at the Ministerial level.

The nature of the problems encountered by OVC, as with the epidemic itself, is multi-sectoral and can only be addressed through multi-sectoral collaboration. Some key areas for collaboration have been identified in this Action Plan document. As the project unfolds, further areas for collaboration will undoubtedly emerge, including with UN agencies.

The strong involvement of the community in the realisation of the project is one of its greatest assets, as well as one of its greatest threats. If the groundswell of community level activism and support can be realised, as envisaged in the Plan, then the project promises to build on past successes in sensitisation and education at the community level. Community level collaborators, however, will also need to be sensitive to the issues of confidentiality, and to be provided with psycho-social support as they fulfill their roles in the project. To an important extent, this work has already begun with the participatory planning process that brought about this Plan.

Once the staffing and oversight mechanisms are in place and the coalitions have been formed, there is every reason to believe that this Plan can be sustained through the collaboration of government, civil society and the private sector. In many instances, the Plan builds on projects and activities already under way. One of the most controversial strategies in the Plan—advocacy for universal access to anti-retrovirals—is already being debated at the Ministerial level. The Ministry of Health has taken concrete steps to reduce the price of the drugs, notably through its leadership in the Caribbean negotiations with the World Health Organisation's (WHO) Accelerating Access Programme, as well as in its more recent negotiations regarding access to generics.

Once the protocols are established and the OVC project has been carefully monitored, evaluated, and adapted in line with its goal, purpose and mission, and with input from the implementers themselves, it could be absorbed into the existing matrix of the public service, civil society, the informal sector and the private sector. In this process, adherence to an effective monitoring and evaluation process, as outlined in the Plan, will also be critical to ensuring that change is taking place at the community level. Here again, addressing stigma and discrimination will be key to the success of the intervention, paving the way for the effective application of the project protocols, and the successful implementation of the project at the grassroots level.

UNICEF has agreed to sponsor four pilot parish projects as part of the first phase of the implementation of this project. This beginning, as well as efforts undertaken independently of these pilot projects, will need to be supported and provided with technical assistance.

Finally, at each step of the implementation process, two critical ideas must be established:

It is essential that young people be involved in developing and evaluating messages that affect their lives. Suitable mechanisms need to be found to create this kind of interface with young people, and they need to be encouraged to make themselves part of the programme implementation - for example by creating “clubs” at schools, writing and performing music or plays, meeting kids from other areas, forming focus groups to discuss messages and evaluate campaigns, and so on. This is true for both HIV/AIDS reduction messages, and for OVC programmes.

Any plan of action must ensure that PLWHA are not publicly differentiated, for example by using special rooms, staff, procedures or any other visible markers that can be used by the public or other staff to identify a client as a PLWHA. This is critical to any intervention involving PLWHA and those affected by HIV/AIDS.

Next Steps

Under the leadership of the Child Development Agency at the Ministry of Health, this working document is being distributed to all stakeholders, including the National AIDS Committee, the National AIDS Programme, as well as key stakeholders in NGOs, CBOs and FBOs involved in the care and treatment of children, PLWHA and OVC. The Plan is to serve as a guide for regional and parish level work plans that would, themselves incorporate these indicators and time-frames. The Plan is also being disseminated to other government ministries and international agencies for incorporation in their plans and programmes.

THE NATIONAL PLAN OF ACTION FOR ORPHANS AND OTHER CHILDREN MADE VULNERABLE BY HIV/AIDS IN JAMAICA

Narrative	Objectively Verifiable Indicators	Means Of Verification	Outcomes	Impacts	Assumptions
<p>GOAL Enhance the quality of life for orphans and other children made vulnerable by HIV/AIDS in Jamaica.</p>	<p>Mortality rate from AIDS reduced # policies in place to address OVC at the community/parish level % vulnerable children accessing existing social services increased</p>	<p>Epidemiological surveillance system OVC Plan of Action monitoring and evaluation system Community/ Parish-level reports on OVC-related activities Economic and Social Surveys of Jamaica Surveys of Living Conditions</p>	<p>Quality of life for orphans and other children made vulnerable by HIV/AIDS in Jamaica enhanced.</p>	<p>Improved integration of orphans and other children affected by HIV/AIDS into the mainstream of society.</p>	<p>That stigma can be reduced. That formal and informal social support networks will be responsive to education campaigns.</p>
<p>OBJECTIVE Incidence of orphaning reduced, and vulnerability of children who are infected or affected by HIV/AIDS reduced.</p>	<p>Numbers of AIDS orphans reduced Numbers of HIV-positive children aged 0-18 declining; Mortality rate from AIDS reduced; Median survival of PLWHA increased</p>	<p>Epidemiological surveillance system; National Plan of Action for Orphans and Other Children Affected by HIV/AIDS evaluation.</p>	<p>Impact of HIV/AIDS on caregivers and children reduced.</p>	<p>Increased productivity and quality of life for orphans and other children affected by HIV/AIDS.</p>	<p>Spread of the HIV/AIDS epidemic will continue to be slowed. Economic conditions affecting poverty in the country can remain stable.</p>

Narrative	Objectively Verifiable Indicators	Means Of Verification	Outcomes	Impacts	Assumptions
<p>OUTPUT 1 Capacity of families and institutions to care for OVC strengthened.</p> <p>STRATEGIES</p> <ul style="list-style-type: none"> a) Identify potential caregivers, foster parents, vulnerable children and families in need of support. b) Provide practical psycho-social, material and spiritual support (i.e.: capacity building) to children and families infected and affected by HIV/AIDS. c) Help affected households to develop income-generating activities to strengthen their capacity to care for OVC. 	<p>% of families with enhanced capacity to care for OVC.</p>	<p>Parish-level progress reports. Independent evaluation.</p>	<p>Families and institutions better able to care for OVC.</p>	<p>Improved quality of life for OVC.</p>	<p>That capacity will be created at parish level to effectively and efficiently perform and sustain this monitoring and evaluation process.</p>

Narrative	Objectively Verifiable Indicators	Means Of Verification	Outcomes	Impacts	Assumptions
<p>OUTPUT 2 Information on existing social services disseminated and services accessed.</p> <p>STRATEGIES</p> <ul style="list-style-type: none"> a) Build awareness of existing social services. b) Build service user skills - know entitlements, eligibility, what to ask for, where to go. c) Ensure user-friendliness of services. d) Ensure confidentiality for PLWHA accessing services. e) Cover key sectors and programmes - education, health, poor relief, other key services. 	<p>% of families with enhanced capacity to care for OVC.</p>	<p>Parish-level progress reports. Independent evaluation.</p>	<p>Families and institutions better able to care for OVC.</p>	<p>Improved quality of life for OVC.</p>	<p>That capacity will be created at parish level to effectively and efficiently perform and sustain this monitoring and evaluation process.</p>

Narrative	Objectively Verifiable Indicators	Means Of Verification	Outcomes	Impacts	Assumptions
<p>OUTPUT 3 Psycho-social support provided to caregivers, orphans and other children made vulnerable by HIV/AIDS.</p> <p>STRATEGIES</p> <p>a) Impart counselling/support skills to existing professionals – teachers, nurses, childcare workers, clerics, church groups, youth leaders, police, and any other group identified who will provide direct services to orphans and other children made vulnerable by HIV/AIDS and their caregivers.</p> <p>b) Train voluntary/ community counsellors – through faith based organisations, community based organisations, among others – to provide support to orphans, other children made vulnerable by HIV/AIDS, and PLWHA with children.</p>	<p>% of OVC receiving psycho-social support.</p> <p>% of caregivers receiving psycho-social support.</p> <p>Number of training programmes held for professionals and volunteers.</p>	<p>Parish-level progress reports.</p> <p>Trainers' reports.</p> <p>Independent evaluation.</p>	<p>Reduction in psycho-social distress among OVC and caregivers.</p>	<p>Improved psychological condition of OVC and caregivers.</p>	<p>That sensitisation and training will lead to effective psycho-social support.</p> <p>Existing professionals and community members will be willing to provide psycho-social support to OVC and caregivers.</p>

Narrative	Objectively Verifiable Indicators	Means Of Verification	Outcomes	Impacts	Assumptions
<p>OUTPUT 4 Stigma against PLWHA and those associated with them reduced. STRATEGIES</p> <p>a) Conduct Behaviour Change Communication campaign to reduce stigma against PLWHA, orphans and other children made vulnerable by HIV/AIDS, and their caregivers.</p> <p>b) Involve children, young people and PLWHA more actively in stigma reduction campaigns.</p>	<p>% of population showing positive/caring attitudes towards PLWHA and those associated with them.</p> <p>% of PLWHA reporting instances of discrimination and stigma.</p>	<p>Results of pre- and post-community survey.</p> <p>Surveys among PLWHA.</p> <p>National Knowledge, Attitudes and Practices Survey, as conducted by National AIDS Programme.</p>	<p>Increased tolerance for PLWHA and those associated with them.</p>	<p>Improved acceptance of and support for PLWHA and those associated with them.</p>	<p>Behaviour Change Communication campaign will lead to attitudinal changes at the community level.</p>
<p>OUTPUT 5 Information on issues faced by OVC co-ordinated and shared with relevant agencies. STRATEGIES</p> <p>a) Establish national structure for co-ordinating and disseminating information for OVC.</p> <p>b) Disseminate information on OVC to relevant decision-makers/implementers, on a planned basis.</p>	<p>Integrated national information system on OVC established.</p> <p>Number of items of information disseminated.</p> <p>Range of stakeholders reached.</p>	<p>Monthly reports from Child Development Agency at national and parish levels.</p> <p>Survey to determine awareness of OVC issues among key stakeholders.</p> <p>Independent evaluation.</p>	<p>Increased awareness of decision-makers and awareness of quality of life and living conditions of OVC.</p>	<p>Better decisions made will mean enhanced efficiency and effectiveness of interventions for OVC.</p>	<p>Information disseminated will lead to better decision making regarding community level care for OVC.</p>

Narrative	Objectively Verifiable Indicators	Means Of Verification	Outcomes	Impacts	Assumptions
<p>OUTPUT 6 Universal access to medication for PLWHA, since healthy parents result in fewer orphans.</p> <p>STRATEGY Advocate for provision of medical therapies that prolong the life of caregivers of OVC.</p>	<p>% of PLWHA caregivers accessing medication in keeping with protocols.</p> <p>Morbidity and mortality rates among PLWHA.</p>	<p>Parish and national reports on PLWHA served.</p> <p>National HIV/AIDS surveillance data.</p>	<p>Increased longevity for PLWHA caregivers</p>	<p>Reduction in numbers of children orphaned or made vulnerable by HIV/AIDS.</p>	<p>Sustained supply of medications for PLWHA caregivers will be available.</p> <p>PLWHA will consent to voluntary counselling and testing and agree to treatment.</p> <p>Health services will have capacity to deliver these medications.</p> <p>PLWHA caregivers will adhere to treatment regimens.</p>

OUTPUT I. Capacity of families and institutions to care for OVC strengthened.

Persons Responsible/Resource Persons/Organisations: CIs, frontline VCCT workers/ counsellors nation-wide, NGOs, CBOs, FBOs, ASO, PAAs, social workers, clinic staff, sensitised and trained community members, line ministries, Child Development Agency.

STRATEGY I(a). Identify potential caregivers, foster parents, vulnerable children and families in need of support.

ACTIVITIES TO SUPPORT STRATEGY 1 (a):

- I(a).i. Utilise and strengthen existing networks (in the governmental and non-governmental sectors) of persons testing positive, thus facilitating the identification of households with orphans or children made vulnerable by HIV/AIDS.
- I(a).ii. Review and adapt reporting forms for persons testing positive for HIV/AIDS and make necessary changes to capture data on orphans or other children made vulnerable by HIV/AIDS.
- I(a).iii. Adapt existing best practice guidelines for HIV/AIDS post-test counselling at governmental and non-governmental institutions to include identification of existing support systems and potential support systems for children made vulnerable by HIV/AIDS. These should include relatives and friends who may be willing to take the children in after their parents' death.
- I(a).iv. Liaise with Child Development Agency at the parish level to identify, recruit and sensitise possible foster parents for children orphaned or otherwise made vulnerable by HIV/AIDS.
- I(a).v. Perform social enquiry investigations to assess the quality of life of children made vulnerable by HIV/AIDS to establish levels of need in their households.

STRATEGY 1(b). Provide practical psycho-social, material and spiritual support (i.e.: capacity building) to families infected and affected by HIV/AIDS.

ACTIVITIES TO SUPPORT STRATEGY 1 (b):

- I(b).i. Assess parenting skills of caregivers and provide ongoing support to improve their parenting skills.
- I(b).ii. Assess psycho-social support network for caregivers and orphans and other children made vulnerable by HIV/AIDS; design appropriate capacity-building for this network, and provide ongoing support.
- I(b).iii. Assess mental health/stress management skills of OVC and caregivers. Provide ongoing support to help them cope with the impact of the virus on their lives.
- I(b).iv. Assess existing income levels. Provide linkages to/oversee enrollment in existing programmes run by government and NGOs that offer material support, as appropriate. (This should be arranged synergistically with economic capacity building, as discussed in the next section.)
- I(b).v. Create support groups for caregivers of OVC and OVC, themselves, where appropriate, through existing service agencies (health clinics, NGOs, FBOs and so on).
- I(b).vi. Through FBOs, assess OVC and caregivers' need for spiritual support and, where necessary, identify resources for spiritual support.

OUTPUT I. Strengthen capacity of families and institutions to care for orphans and other children made vulnerable by HIV/AIDS (OVC).

STRATEGY 1(c) Help affected households to develop income-generating activities to strengthen their capacity to care for OVC.

ACTIVITIES TO SUPPORT STRATEGY 1(c):

- I(c)i Strengthen capacity of households caring for OVC to manage their finances effectively, including spending, saving and credit.
- I(c)ii Help poor households caring for OVC to develop profitable and sustainable income-generating activities.
- I(c)iii. Enable OVC caregivers to access micro-loans and other start-up funding opportunities for income-generating activities.
- I(c)iv. Provide ongoing technical support to caregivers/households caring for OVC, which are engaged in income-generating programmes, and develop monitoring systems and targets in association with participants.
- I(c)v Provide technical skills training through enrollment in HEART programmes.

OUTPUT II. Information on existing social services disseminated and services accessed.

Persons Responsible/Resource Persons/Resource Organisations: NGOs, CBOs, FBOs, PHAs, RHAs, PAAs, NAC, BCC component of the JNHACP, line ministries, FBOs working with PLWHA, Child Development Agency.

STRATEGY II(a) Build awareness of existing social services.

ACTIVITIES TO SUPPORT STRATEGY II(a):

- II(a)i. Develop, distribute nationally, and update every two years a user-friendly directory of services available for children and their caregivers, including PLWHA. Include breakdown by parish, region and national programmes, services through clinics, local arms of governmental and non-governmental agencies that provide services to children and caregivers. The directory should indicate what each agency offers and eligibility requirements. Distribute directory through, for example, VCT centres, PAAs, NGOs, FBOs, CBOs and CDA offices.
- II(a)ii. Develop training for persons working with OVC and caregivers at the national, regional, parish and community levels. Provide information on services available, eligibility criteria (such as age or income requirements), forms required by the services, the information required by the forms, how to fill out the forms, and how to assist eligible clients in accessing the different services available. Utilise case studies to show the many ways in which HIV/AIDS affects families living in poverty, emphasising the effect of HIV on PLWHA, caregivers, orphans and other children made vulnerable by HIV/AIDS. Provide training in inter-parish and intra-parish referrals.

OUTPUT II. Information on existing social services disseminated and accessed.

STRATEGY II(b) Build service user skills - know entitlements, eligibility, what to ask for, where to go.

ACTIVITIES TO SUPPORT STRATEGY II(a):

II(b).i. Train regional, parish and community level persons working with OVC and caregivers on how to build client awareness (including children's awareness) of their rights to services, the range of services, the eligibility requirements, and how best to utilise available resources.

II(b).ii. Develop and distribute publication(s) in a simple format on service user rights to government services and ways to handle barriers to accessing services.

II(b).iii. Distribute publication(s) in a simple format on service user rights as a tool for resource persons working to develop service user skills among the citizenry, including PLWHA with children, as well as caregivers of orphans and other children made vulnerable by HIV/AIDS. Be sure to include publication(s) for youth 10-18 years of age.

II(b).iv. Advocate for the development and implementation of ongoing media campaigns to include jingles, television spots, and brief radio skits aimed at raising service user awareness of their rights to social services, and to the fact that there are a range of social services available to the public, and where to access their free directory/guide.

STRATEGY II(c) Ensure user-friendliness of services.

ACTIVITIES TO SUPPORT STRATEGY II(c):

II(c).i. Conduct training sessions for all client-contact staff providing social services - whether government or NGO - in service user rights, including service user rights for the mentally and physically challenged, and conflict resolution at points of service.

II(c).ii. Develop capacity to gather information on levels of client satisfaction and sources of client dissatisfaction and use data to improve user-friendliness of service.

II(c).iii. Establish rewards and penalties system for staff. Include client feedback regarding user-friendliness of services in the criteria.

II(c).iv. Hold supervisors accountable for staff behaviour. Develop and integrate rewards and penalties for supervisors whose staff consistently rate above or below average for user-friendliness of services as part of existing performance review systems.

II(c).v. Develop service user rights materials for display throughout service organisations, including waiting rooms, as well as corridors and rooms in which clients are seen (for example brightly coloured posters, as well as pamphlets in a simple format). Include information on customer complaint system.

II(c).vi. Modify physical environment as necessary to make services accessible to the mentally and physically challenged.

OUTPUT II. Information on existing social services disseminated and accessed.

STRATEGY II(d) Ensure confidentiality for PLWHA accessing services.

ACTIVITIES TO SUPPORT STRATEGY II(d):

- II(d).i. Incorporate into staff training sessions issues of confidentiality and protocols for maintaining confidentiality regarding medical status. Include methods of discussing with clients the risks and rewards of sharing their health status with others, irrespective of whether a person is HIV-positive or HIV-negative.
- II(d).ii. Strengthen system for reporting breaches of confidentiality and develop rewards and penalties system for persons working in service delivery. These should be based on client feedback as part of staff performance appraisal system.
- II(d).iii. Hold supervisors accountable for staff breaches of confidentiality and develop and integrate penalties for supervisors whose staff frequently breach confidentiality of clients.
- II(d).iv. Train staff to educate clients in respecting their own right to confidentiality regarding their health status, and the rewards and risks of disclosure of their health status to others.
- II(d).v. Evaluate and address as necessary, information storage and retrieval systems so as to ensure that serostatus of clients or their families or caregivers remain confidential.
- II(d).vi. Gain client permission for all HIV-related referrals to ensure informed consent.

STRATEGY II(e) Cover key sectors and programmes - education, health, poor relief, other key services.

ACTIVITIES TO SUPPORT STRATEGY II(e):

- II(e).i. Ensure that implementation of the Plan of Action is multi-sectoral and covers, at a minimum, all the government departments and non-government agencies identified in the directory of services for child and family welfare, PLWHA, and caregivers of OVC.
- II(e).ii. Ensure staff development activities identified in the Plan of Action are implemented, monitored and evaluated in collaboration with relevant line ministries and relevant NGOs and donors.
- II(e).iii. Publish standards for professional conduct towards clients accessing social services to include OVC, their caregivers, and PLWHA.
- II(e).iv. Ensure that serostatus is only identified where required for service provision and is not identifiable through special referral systems, reporting forms, or any other marker that would allow the public or staff to identify PLWHA or those related to them.
- II(e).v. Ensure that Ministry policies on HIV/AIDS are effectively and appropriately implemented to support Ministry commitments to PLWHA, caregivers, to orphans and to other children made vulnerable by HIV/AIDS.
- II(e).vi. Hold supervisors in all agencies identified in the directory of services accountable for maintaining protocols and published standards for quality service established in the Plan of Action.

OUTPUT III. Psycho-social support provided to caregivers, orphans and other children made vulnerable by HIV/AIDS.

Persons Responsible/Resource Institutions: Child Development Agency, line ministries, service providers at the local, regional and national levels, PAAs, NAC, RHAs, identified training institutions nation-wide, CBOs, NGOs, FBOs, PHA, CIs, community leaders.

STRATEGY III(a) Impart counselling/support skills to existing professionals – teachers, nurses, childcare workers, clerics, church groups, youth leaders, police, and any other group identified who will provide direct services to orphans and other children made vulnerable by HIV/AIDS and their caregivers.

ACTIVITIES TO SUPPORT STRATEGY III(a):

- III(a).i. Include profession-appropriate information and skills on HIV/STI in training and certification curricula at the institutional level—colleges, universities, medical schools, nursing schools, police academies, seminaries, theological schools, teacher-training colleges and social work training centres, among others, for each of the groups identified in the strategy and any other groups who may work with OVC, PLWHA and caregivers.
- III(a).ii. Develop a continuing education system for these groups, and build into the certification process (where certification is in place) successful completion of HIV/AIDS modules providing counselling and referral, and addressing myths about transmission, universal precautions, human rights of children and PLWHA, and the impacts of HIV/AIDS on families and, in particular, children.
- III(a).iii. Actively recruit principals, vice-principals, teachers, ancillary and clerical staff, pre-school and day care workers, guidance counsellors, parents and parent-teacher associations to attend training and sensitisation sessions on HIV/AIDS, which will include counselling and referral, dispelling myths about transmission, the importance of universal precautions, the human rights of OVC and PLWHA (including the right of HIV-positive children to schooling) the impacts of HIV/AIDS on families and OVC, as part of the dissemination of the Ministry of Education policy on HIV/AIDS.
- III(a).iv. Conduct similar sensitisation sessions for social workers and others engaged in the social service sector, particularly those to whom OVC and their caregivers will be referred, and involve these professionals in the design and implementation of the training and sensitisation workshops.
- III(a).v. Through the local office of the Caribbean Council of Churches and other religious umbrella organisations or headquarters, recruit clerics and conduct similar sensitisation sessions to include the role of religious leaders and FBOs in providing support to OVC and their caregivers. Establish contact persons in churches to facilitate ongoing training and referral.
- III(a).vi. For staff at all centres offering health services—from porters through to administrators—provide training and sensitisation to re-orient workers in the health system toward professional, non-judgmental and humane delivery of health services for PLWHA, including basic HIV/AIDS facts, universal precautions, management of accidental injuries, dispelling myths about transmission, the human rights of children and PLWHA, and the impact of HIV/AIDS on OVC and their caregivers.
- III(a).vii. Identify community organisations and special target groups for sensitisation through more innovative means (e.g. walk and talks, combined with special sessions at their meetings) to include such groups as citizen's associations, taxi and mini-bus operators, neighbourhood watch groups and senior citizens.
- III(a).viii. Encourage inclusion of HIV/AIDS sensitisation in all orientation programmes at targeted institutions.
- III(a).ix. Assess, on a case-by-case basis, levels of psycho-social distress among OVC and their caregivers, whether HIV-positive or HIV-negative, and ensure they receive appropriate support, either at the point of diagnosis (e.g. in school, hospital, NGO, etc.) or when referred to appropriate professionals or agencies.

OUTPUT III. Psycho-social support provided to caregivers, orphans and other children made vulnerable by HIV/AIDS.

- III(a).x. Foster and support informal networks, as required, within and outside the community for caregivers and orphans and other children made vulnerable by HIV/AIDS.
- III(a).xi. Conduct ongoing evaluation of existing programs to provide psycho-social support for PLWHA caregivers and other caregivers of orphans and other children affected by HIV/AIDS.

STRATEGY III(b) Train voluntary/ community counsellors – through faith based organisations, community based organisations, among others - to provide support to orphans, other children made vulnerable by HIV/AIDS, and PLWHA with children.

ACTIVITIES TO SUPPORT STRATEGY III(b):

- III(b).i. Through school teachers, nurses and social workers, NGOs, CBOs and FBOs, identify and recruit voluntary counsellors for sensitisation and training in care and support of OVC, PLWHA and caregivers.
- III(b).ii. Obtain, as a prerequisite for enrollment for training sessions, a commitment to serve OVC and to attend quarterly meetings for monitoring, feedback and support for a period between six months and one year. Identify and provide appropriate incentives for the prescribed period.
- III(b).iii. Appoint OVC focal points, in collaboration with co-ordination committees and training agencies, to implement, monitor and improve programmes to support voluntary counsellors, and to conduct twice per year meetings, beginning in the second year, for monitoring and evaluation of this strategy. These meetings will also be important opportunities to obtain feedback from and provide support for trainees in the field.

OUTPUT IV. Stigma against PLWHA and those associated with them reduced.

Persons Responsible/Resource Persons/Resource Organisations: Youth.now, sensitised NGOs, CBOs, and FBOs, line ministries, PAAs, NAC, media houses, sensitised PR firms and PR consultants, BCC specialists at the Ministry of Health, RHAs and PHAs, JN+, JAS, CHARES, Child Development Agency.

STRATEGY IV(a). Conduct Behaviour Change Communication campaign to reduce stigma against PLWHA, orphans and other children made vulnerable by HIV/AIDS, and their caregivers.

ACTIVITIES TO SUPPORT STRATEGY IV(a):

- IV(a).i. Use behaviour change strategies to address popular myths regarding the rights (or lack of rights) of children, PLWHA and children of PLWHA.
- IV(a).ii. Monitor and assess the response to the PR campaign through monthly feedback sessions with key social sector leaders and lay persons at the community, national and regional levels (e.g. churches, police, schools, day care centres), and six-monthly surveys of the target audiences. Ensure that any resistance to the messages is understood, allow for debate over the content and attitudinal change and feed information back to the co-ordinators of the PR campaign.
- IV(a).iii. Conduct sensitisation workshops for a range of groups to reinforce and to process messages in the PR campaign, including disc jockeys, higglers, informal commercial importers, among others. Be sure to include fora for students to sensitise them to the issues of stigma, discrimination, as well as delaying initiation of sex and abstinence.
- IV(a).iv. Evaluate PR campaign and use evaluation data to feed back into a renewal of the de-stigmatisation and sensitisation public awareness campaign, as needed.

OUTPUT IV. Reduced stigma against persons living with HIV/AIDS and those associated with them.

STRATEGY IV(b). Involve children, young people and PLWHA more actively in stigma reduction campaigns.

ACTIVITIES TO SUPPORT STRATEGY IV(b):

- IV(b).i. Identify PLWHA who are willing to disclose their status at community, regional and national levels and train in public speaking. Adequate and comprehensive support will have to be in place before any spokesperson can go public under this programme. This may include professional sensitisation and support for the family on issues of PLWHA going public.
- IV(b).ii. Utilise PLWHA in sensitisation sessions at the community, regional and national levels, to include media campaigns designed to humanise the image of PLWHA and to create awareness of the challenges faced by their children, largely as a result of the prejudice and ignorance of others.
- IV(b).iii. Identify spokesperson(s) to lead the fight against stigmatisation and discrimination against PLWHA and OVC. Such a spokesperson would need debriefing and counselling support, and to have their personal safety assured by the programme, and may come from either the PLWHA or OVC communities.

OUTPUT V. Information on issues faced by OVC co-ordinated and shared with relevant agencies.

Persons Responsible/Resource Persons/Resource Organisations: Child Development Agency, PAAs, PHAs, RHAs, JN+, JAS, CHARES, NAC, Hope Worldwide, Children First, Coalition for Better Parenting, Fathers Inc., other NGOs, CBOs, and FBOs working with PLWHA and OVC.

STRATEGY V(a). Establish national structure for co-ordinating and disseminating information for OVC.

ACTIVITIES TO SUPPORT STRATEGY V(a):

- V(a).i. Establish post for national OVC Focal Point within Child Development Agency that reports to the National Steering Committee on co-ordination and implementation of the National Plan of Action.
- V(a).ii. Mandate OVC Focal Point to collate community, parish and regional level documentation on OVC issues in collaboration with other relevant agencies, and issue regular analysis of these data to reflect the living conditions of OVC, the protection of children's rights, and progress in each of the areas of this Plan of Action under the leadership of the National Steering Committee on OVC.

STRATEGY V(b) Disseminate information on OVC to relevant decision-makers/implementers, on a planned basis.

ACTIVITIES TO SUPPORT STRATEGY V(b):

- V(b).i. The publication of data, as envisaged in the previous section, by the National OVC Focal Point, will be achieved through printed media (e.g.: regular report or newsletter), meetings, emails and website, designed to reach all decision-makers and programme implementers inside and outside of government, along with other stakeholders, such as beneficiaries (OVC and PLWHA), donors and mass media.

OUTPUT VI. Universal access to medication for PLWHA, since healthy parents result in fewer orphans.

Persons Responsible/Resource Persons/Resource Organisations: The CMO, NAP, RHAs, PHAs, health workers, OVC Focal Points, Child Development Agency, JN+, JAS, CHARES, Hope Worldwide, PAAs, NAC, Kiwanis, Lions Clubs, Optimists, and other NGOs, CBOs and FBOs working to reduce the spread of HIV/AIDS in Jamaica.

STRATEGY VI (a) Advocate for provision of medical therapies that prolong the life of caregivers of OVC.

ACTIVITIES TO SUPPORT STRATEGY V:

VI(a)i Monitor and lobby for the Accelerating Access Programme* and other cost reduction strategies in Jamaica to be fast-tracked to the maximum extent possible and to be implemented at the community level in a safe, efficient and effective manner.

VI(a)ii Involve private sector entities and international organisations in the planning process for greater access to anti-retrovirals, and lobby for a greater contribution in the provision of anti-retrovirals. Lobby for medication under the existing prevention of mother to child transmission programme on grounds of ethical treatment of PLWHA mothers and the rights of the child made vulnerable by HIV/AIDS.

VI(a)iii Assess each PLWHA's total health condition to ensure maximum benefit from anti-retrovirals. Monitor, on an ongoing basis, client compliance with anti-retroviral regimes.

VI(a)iv Provide anti-retroviral therapies in patient-friendly environments.

VI(a)v Establish system to monitor patient adherence to anti-retroviral therapy.

