Draft Strategic Plan for Positive, Health, Dignity and Prevention

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Document serves as a guide to integrate the principles of PHDP into the overall HIV response of Jamaica, using the PHDP curriculum as the grounding document.

Streamlining PHDP into the HIV Response

Contents

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Special thanks to the members of the steering committee.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CF	Community Facilitator
CCM	Country Coordinating Mechanism
CHARES	Centre for HIV/AIDS Research, Education and Services
EEHR	Enabling Environment and Human Rights Unit
EFL	Eve for Life
GIPA	Greater Involvement of People Living with HIV
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GNP+	Global Network for and by People Living with HIV
HIV	Human Immuno-deficiency Virus
HST	HIV/STI/Tb Unit
ICW	International Community of Women Living with HIV
JASL	Jamaica AIDS Support for Life
JCW	Jamaica Community of Women Living with HIV
JN+	Jamaica Network of Sero-positives
M&E	Monitoring and Evaluation
MOH	Ministry of Health
NASA	National AIDS Spending Assessment
NERHA	North East Regional Health Authorities
NFPB	National Family Planning Board
NISP	National Integrated HIV and Sexual Health Strategic Plan
PHDP	Positive Health, Dignity and Prevention
RHA	Regional Health Authority
SERHA	South East Regional Health Authority

SRHA	Southern Regional Health Authority
UNAIDS	The Joint United Nations Programme on HIV/AIDS
WRHA	Western Regional Health Authority

1. Summary

Positive Health, Dignity and Prevention (PHDP) is underpinned by the Greater Involvement of People Living with HIV/AIDS (GIPA) concept. The core components of PHDP become the nexus of positive prevention with that of greater and meaningful of involvement of PLHIV in directing their health and well-being. This means that PLHIV are the epicentre of the response at all levels.

With the capacity building needs of PLHIV and key populations for a new global approach to actualise GIPA and reconceptualise Positive Prevention, PHDP Curricula have been developed in various countries and one of them is Jamaica. Implementation of the PHDP Curriculum primarily targeted PLHIV community leaders, other key populations group leaders and health Care workers Seventy-five (75) PLHIV graduated from PHDP capacity building training which guided by the PHDP curriculum developed by PLHIV in Jamaica with technical assistance from Health Policy Plus. Twelve of these graduates have gone on to be Community Facilitator (CF) at treatment sites. These CFs assist other PLHIV to navigate the public health system thus contributing to retention in care.

It is benefits such as these which make the Enabling Environment and Human Rights Unit of the National Family Planning Board think that it is prudent to develop a PHDP strategic plan which should direct the integration of PHDP into all relevant HIV programming within and outside of the health sector.

A strategic plan was developed in consultation with EEHR unit and key stakeholders in the PLHIV response such as the community facilitators, PLHIV leaders, healthcare workers and other HIV leaders at the national and regional levels.

Four priority areas were identified:

1. Governance and Leadership
2. Community Engagement
3. PLHIV Health and Well-being
4. Monitoring and Evaluation.

The plan has three guiding principles which are inclusion, communication and dignity as it is recognized that the only way to achieve the health, well-being and dignity of PLHIV and other vulnerable groups is to into include stakeholders across all sectors by ensuring communication.

Four strategic objectives were identified. They are:

1. Strengthened leadership, management and coordination of PHDP Framework
2. Integration of PHDP and its core components into existing and future programmes with key stakeholders in order to increase the physical and psycho-social wellbeing of PLHIV
3. Strengthened PLHIV Human Rights and Rights Based Advocacy and Policy Development by integrating PHDP Core Components into multi-sectoral Policies and Programmes
4. Improved Monitoring and Evaluation of PHDP Programming ensuring its alignment to national strategic plans and policies and programmes.

Through good governance and leadership the PHDP strategy should be implemented thus leading to greater health and psycho-social indicators for all PLHIV as a result of increased linkage to care as access

to health and social services are increased because of multi-sectoral interventions guided by the PHDP framework. This will then lead to goals of utilising PHDP to:

- Reduce HIV-related Stigma and Discrimination in the society
- Advance Jamaica's Progress towards 90/90/90

The effectiveness of the strategic plan is also founded on the proper implementation of Monitoring and Evaluation activities to ensure that the plan is making the impact that is should. Additionally, funding of the plan is essential. Without fiscal or technical resources some of the activities may not be implemented thus reducing any impact of the PHDP strategic plan. To this extent maximizing on the strengths of partners and stakeholders is beneficial. Further to this implementation must ensure equity for PLHIV and vulnerable groups.

2. Background & Introduction

The bedrock of the declaration made at the 1994 Paris AIDS Conference was that of the Greater Involvement of People Living with HIV/AIDS (GIPA). The principle speaks to the involvement of PLHIV at all levels of the response, whether in the community, nationally or internationally. The principle of GIPA has matured over the years and has become operationalized in the concept of the PHDP framework, which includes the concepts of Positive Prevention and the inclusion of PLHIV in the response as well as the acknowledgment of the human rights and dignity of the patient. The PHDP policy framework was put forward by UNAIDS and Global Network of People Living with HIV (GNP+) in 2011 and provides guideline for all PHDP policies, plans and programmes.

This complex system takes into consideration the patient is more than a vessel for HIV transmission. It recognizes that the patient is one with human with rights and must be supported inside and outside of the health system to be healthy. The PLHIV will not only be a citizen who contributes t to the decline of HIV but also one who contributes positively to the growth and wealth of their community and by extension their country.

GIPA has seven steps in its cycle. These seven principles have been seen in Jamaica, with the PHDP curriculum being an example of operationalizing GIPA especially as the HIV response locally and internationally matures. PHDP curriculum can be seen as the content which guides the operationalization of GIPA. Implementing a PHDP programme involves the steps seeing in table 1.

PHDP which signifies the operationalization of GIPA through eight core components. These core components are:

1. Empowerment of PLHIV and networks of PLHIV
2. Stigma and Discrimination
3. Sexual and Reproductive Rights
4. Gender
5. Health promotion and access
6. Prevention of new infections
7. Social and economic support
8. Measuring impact

The PHDP Curriculum was developed with the involvement of PLHIV Leaders, the GIPA Capacity Building Programme located within the EEHR Unit, National Family Planning Board . Since 2012 ninety-five (95) PLHIV have participated in Information and Knowledge Exchange Workshop and Communication Skills Clinics using modules of the PHDP Curriculum, yielding seventy-five (75) graduates. One hundred and sixty-six (166) HCW at Treatment Sites across the island, including JASL, were trained in PHDP modules such as Treatment Literacy and Disclosure with PLHIV being involved as facilitators in these training. The capacity of approximately one hundred and fifty (150) MSM have been built in PHDP and another three hundred (300) MSM reached by peers trained in PHDP. Sixty (60) FSWs have been reached by PHDP Peers in WRHA. One of the greatest achievements of PHDP is the deployment of twelve (12) Community Facilitators since 2014 to more than 50% of PEPFAR high volume sites.

It should be noted that Jamaica has several other interventions which are underpinned by the GIPA concept and the PHDP framework. These include the mentor mom programme of Eve for Life CW+ advocacy support groups and support groups managed by Regional Health Authorities (RHAs) Further to this, as part of the Global Fund's Country Coordinating Mechanism (CCM), several PLHIV from organizations such as JN+ and JCW+ represent the voice of PLHIV in directing the country's national HIV response. JN+ also has a reporting and redress system which has recently been re-named to the Jamaica Anti-Discrimination System. Its aim is to collect reports on all perceived or real incidents of stigma and discrimination.

The table below highlights the work and some of the achievement under GIPA to PHDP. However in order to move forward a more coordinated approach is needed. This approach needs to have the individual living with HIV at the epicentre of the response which then feeds into the wider community and support systems.

Table 1 Operationalization GIPA in Jamaica

Steps of GIPA	Description	- Examples
Personal	People living with HIV are actively involved in their own health and welfare. They take an active role in decisions about treatment, self education about therapies, opportunistic infections and adherence, and positive prevention.8	- Reports of women in Focus Groups requesting SRH information as it relates to Planned Pregnancy
Treatment Roll-out and Preparedness	People living with HIV support treatment roll-out through educating others on treatment options, side effects and adherence, and are involved as home-based and community health-care workers	- Adherence Counsellors - Community Facilitators - Mentor Moms (EFL) - Multi-disciplinary Treatment Team
Policy Making Process	People living with HIV participate in the development and monitoring of HIV-related policies at all levels.	- JN+ - JCW+ - Enabling Environment Leadership - CCM
Programme Development and Implementation	People living with HIV provide knowledge and skills towards universal access through participation in the governance of global organizations such as UNAIDS and the Global Fund and in the choice, design, implementation, monitoring and evaluation of prevention,	- GIPA Coordinator/GIPA Unit - JN+ partnership with GN}+ and Govt of Jamaica - JCW partnership with ICW and GNP - Cadre of PLHIV Leaders on the board of CCM

Steps of GIPA	Description	- Examples
	treatment, care and support programmes and research.	-
Leadership and support, group networking and sharing	People living with HIV take leadership of HIV support groups or networks, seek external resources, encourage participation of new members or simply participate by sharing their experiences with others.	- JN+ - JCW+ - Treatment Site Based Groups - Mentor Mom Programme EFL - Members of CCM
Advocacy	People living with HIV advocate law reform, inclusion in the research agenda and access to services, including treatment, care and support; and for resource mobilization for networks of people living with HIV and for the broader response.	- CCM Membership - JASL advocacy programmes with PLHIV and key populations - JN+ - JCW
Campaigns and public speaking	People living with HIV are spokespersons in campaigns or speakers at public events and in other arenas.	-PHDP Trained individuals go to workplaces and schools - Ads on television PLHIV Speakers' Bureau

Currently, the PHDP curriculum does not address components seven and eight. This indicates a level of weakness with the implementation model of PHDP in the island. This therefore means that the benefits and impact of PHDP are possibly not being measured accurately and currently, this therefore affects PHDP planning as well as that in the wider HIV response. This then reduces the potency and impact of the HIV response on its beneficiaries, PLHIV. Further to this social and economic management is extremely important if the total well-being of the PLHIV individual is to be addressed. Therefore initiatives which incorporate this aspect of the PHDP core concepts need to be enhanced and developed.

3. Rationalization for the Strategic Plan

In 2014 UNAIDS introduced the 90-90-90 strategy as a means to reach the goal of elimination of the HIV/AIDS pandemic by 2030. This means that by 2020, 90% of people living with HIV will know their status, and 90% of those who have been diagnosed will have been retained in care and receiving sustained anti-retroviral therapy and 90% of those will be virally supressed.

As part of its mandate to achieve this goal, Jamaica introduced "test and start" in January 2017. Currently, the country' s profile as it relates to 90-90-90 stands at 81-43-55, indicating that a great deal of work needs to be done if the 2020 international benchmark is to be achieved. The PHDP Policy Framework of 2011 put forth by UNAIDS and GNP+ highlight the importance of those infected and affected at the centre of the HIV response, especially in managing their health. This means that PLHIV are not just a vector for passing the virus but have other needs which impact their full health such as psychosocial needs and their decisions need to be from a rights based perspective. When these criteria are met it is believed that better health outcomes will be seen for the individual. This will be translated to more individuals being retained in care and increased viral suppression. The impact of this will be reduced HIV transmissions over time.

3.1 Strengths and Opportunities

It has long since been stated that those who know their HIV status are more likely to manage their health better[1] however a supportive environment which increases the individual's knowledge and capabilities around managing the illness is a must[23]. It cannot be taken for granted that the individual understands the nature of the illness based on diagnosis only[4]. The PHDP framework becomes integral in this process as it seeks to address not just the health related support systems but the other systems such as the legal, political, psychological and socio-economic aspects which can affect positive health outcomes.

In Jamaica, the PHDP Curriculum has played an important role in operationalizing the GIPA principles as well as being a guiding document as it relates to the concept of PHDP in the country. The curriculum seems to have had an impact on those who benefitted from the GIPA Capacity Building Programme. These include the five cohorts who were trained using the curriculum, as well as, those PLHIV who have encountered health care workers who have had their professional abilities strengthened through PHDP. These include but are not limited to adherence counsellors, social workers and community facilitators.

There is evidence to indicate that exposure to PHDP curriculum and concepts have played an important role not only in the professional development of healthcare workers but to PLHIV who have encountered workers who have been exposed to PHDP or to other peers who have experienced PHDP. This multiplier effect can be used to improve the health and well-being outcomes of PLHIV not only in the health sector but also in education and social protection. Hence; the need for more PLHIV leaders at the national and

[1] https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001873
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4709521/#R10
[3] https://hqlo.biomedcentral.com/articles/10.1186/1477-7525-10-53
[4] Positive Health, Dignity and Prevention- A Policy Framework, GNP+ and UNAIDS http://www.unaids.org/sites/default/files/media_asset/20110701_PHDP_0.pdf

sub-national levels, who benefit from PHDP and can (or be mentored to) direct programmes and advocate/support policy development based on the needs of their peers.

Further to this PHDP and its concepts can improve the work of existing NGOs and community groups which are involved in the response as the empowerment of the PLHIV is at the epicentre of most of the work of these organizations. While further research is needed, the impact evaluation of the PHDP curriculum seems to indicate that when PLHIV are associated with PLHIV support groups and NGOs, as well as, being continually exposed to content of empowerment they seem to report better health indicators, this therefore strengthens the argument to ensure a concerted effort to coordinate and integrate the core components of PHDP into the entire HIV response. This finding is consistent with the literature over the years. [5]

3.2 Gaps, Challenges and Weaknesses

Whilst the PHDP Curriculum has been the guiding document for building the capacity of PLHIV in Jamaica and involving PLHIV in the response and their own healthcare, many gaps still exist. Although PHDP has been used to build the capacity of approximately 150 MSM to date as well as healthcare staff across the island, for the most part, PHDP remains insular and not integrated in the entire HIV response because of inadequate funding.

Going forward coordinated leadership is going to be required to ensure an expanded and improved partnership. For the greatest national impact the partnerships must capitalize on the strengths of each partner and stakeholder. Another weakness of the implementation of PHDP in Jamaica is that there seems to be limited PLHIV community leadership involved in national advocacy and human rights activities.

While the responsibility to implement PHDP-related capacity building initiatives resides within the enabling environment unit of the NFPB, most of PHDP is being operationalized in the treatment and care area. This reflects the heart of the PLHIV priority – access to treatment and the intent to reach viral suppression. However; it is important that similar attention is given to the empowerment of the PLHIV in the development of priorities in areas such as cultural rights, and related advocacy and policy monitoring. The impact evaluation shows that there is little transfer of knowledge regarding systems of redress and reporting and their importance in this process and how they assist in reducing stigma and discrimination and in turn providing safe spaces for accessing of services which will contribute towards the total health and well-being of the individual.

This also speaks to the implementation of PHDP outside of the health sector. Currently, most PHDP related capacity building takes place within and are driven by the health sector. In order for PHDP to have an impact the implementation of further capacity building to drive demand for PHDP must also include a concerted effort to engage sectors such education, social protection and labour. This will also address the social and economic support as a priority of PLHIV, so while not written in the curriculum for capacity building the concept can be integrated throughout the various sectors to ensure the well-being of PLHIV.

[5] https://www.researchgate.net/publication/233114589_The_Benefits_of_Women-Only_HIV_Support_Groups

The National HIV Policy states that "*PHDP should be emphasized as a major strategy aimed at reducing HIV transmission*". Adherence and viral suppression are key outcomes under the PHDP Curriculum aimed at overall keeping PLHIV healthy and reducing the risk of transmission. Jamaica's achievement in relation to the 90-90-90 treatment targets is 81-43-55. This indicates that significant steps need to be taken if Jamaica is to achieve the targets set by 2020, particularly as it relates to adherence and viral suppression.

The National Integrated HIV and Sexual Health Strategic Plan (2014-2019) speaks to PHDP as a major driver when linking PLHIV into care and support services. It also recognizes that while PHDP has been used in interventions with the PLHIV and other vulnerable populations, there is a need for HCW to have their capacity built in PHDP in order to ensure the well-being and dignity of the PLHIV community. In fact one of the key actions of Strategic Outcome 3 of the NISP is the revising of the HIV counselling protocol based on PHDP.

Further to this there is a lack of monitoring and quality assurance activities related to PHDP. Interestingly the eighth core component of measuring activities was not included in the PHDP curriculum although it was discussed in capacity building workshops. To ascertain the impact and the effectiveness of PHDP all activities must be measured, monitored and evaluated. These activities are also hinged on strong coordinated multi-sectoral leadership of PHDP to ensure reasonable improvements in the quality of life of PLHIV and key populations beyond the health sector..

4. Strategic Plan Development Process

In 2017 a consultant was hired to develop the framework for mainstreaming PHDP. The framework was the beginning of further integrating PHDP into all HIV activities and creating a unified platform for all PLHIV membership and service organizations to improve the health, well-being and dignity of their clients.

The process was participatory and included focus group discussions and in-depth interviews with key stakeholders such PLHIV, Healthcare workers as well as leaders and technical staff in the HIV response. From this process an initial five strategic objectives along with suggested outputs were identified. In May 2018, another consultant was hired to conduct an Impact Evaluation of the PHDP Curriculum as well as to develop a five year strategic plan based on this recommended framework. The initial five strategic objectives which were identified and then modified included::

1. Strengthened leadership, management and coordination of the PHDP programme

2. Strengthened capacity of the PLHIV and key partners in PHDP to increase their involvement in the comprehensive delivery of holistic high quality health care services to community

3. Strengthened the role of PLHIV in development and implementation of policies and related programmes to enable them to live healthy lives.

4. Improved advocacy for policy and structural changes to facilitate a continually improved enabling environment for PLHIV, families and partners.

5. Improved quality assurance and monitoring and evaluation of the PHDP programme

The framework was refined to four strategic objectives based on findings from the evaluation as well as consultation with the members of the EEHR division and the GIPA Unit NFPB/SHA. Additionally, the alignment of PHDP with other sector and PLHIV related organizational plans were assessed to assist in the development of the plan. A validation meeting with stakeholders was conducted and their feedback given. These comments, where possible, were incorporated into the strategic plan. Stakeholders were also specifically asked to give feedback on realistic and possible timelines for implementation.

5. The Strategic Plan

5.1 Vision and Mission

For all citizens, whether PLHIV, vulnerable populations or the general population to access quality and equitable services across all sectors ensuring with respect, honour and dignity.

5.2 Guiding Principles of the Strategic Plan

The foundation of the strategic plan is based on three guiding principles. These are;

1. Inclusion
2. Dignity
3. Communication

Inclusion

This principle ensures that strategic plan is for all affected by HIV. This includes PLHIV and other vulnerable populations as well as all stakeholders including civil society, Government, community based groups and other sectors such as the faith based and private sectors. All populations and key stakeholders must be involved and are integral to further the cause of PHDP in Jamaica. This will inevitably assist PLHIV to attain the highest level of health and well-being.

Communication

A missing piece to the success of PHDP over the years is the lack of understanding of PHDP and its role and purpose in the response. It has been seen as insular and isolated. At the heart of the success of this strategic plan is foundation of communication. This principle will have to be utilized to effectively, guide coordinate and direct any PHDP process. Communication means open channels to deliver to and receive information from beneficiary populations, partner organizations and key stakeholders.

Dignity

A mainstay of PHDP is the Dignity of PLHIV and other vulnerable groups. All interventions and actions must be see through the lens which should provide dignity to PLHIV and vulnerable groups. Dignity speaks to all PLHIV and vulnerable populations being treated with honour and respectability no matter the service being received or accessed.

5.3 Priority Areas

After the assessment of PHDP and it is role in increasing PLHIV participation and health and well -being the following are the priority areas of the strategic plan:

1. Governance and Leadership
2. Community Engagement
3. PLHIV Health and Wellbeing using a Rights Based Approach
4. Monitoring and Evaluation

Governance and Leadership

One of the challenges as it relates to PHDP is the seeming disjointed/stand-alone implementation. It is recognized for PHDP to be streamlined into existing HIV policies and programmes, governance and leadership structure and roles must be strengthened. If this is not done the potency and benefits of this concept will not be realized. A more coordinated approach which involves PLHIV leadership and guidance has to be developed and established which can facilitate integration of PHDP, recognizing the strength and weaknesses of all stakeholders. It should be noted that an independent PHDP Programme does not have to be developed however the mainstay is to ensure that the ideals and standards of PHDP are integrated and espoused in all PLHIV related policy and programmes across all sectors.

The leadership structure must ensure it works with sectors outside of health in order to drive the concept of dignity of Key Populations including PLHIV in the response and country. This is especially important in the areas of child protection, social protection, accommodation in the work force as well as in the area of law and justice. This therefore means the leadership has to provide and facilitate an enabling environment to advocate for and include not only health and support programmes and policies but also those related to education, occupational safety and justice. Specifically, the Ministries of Labour and Social Security, the Ministry of Education and Youth, the Ministry of Justice and the Ministries of Local Government must be engaged, this however does not mean other sectors should not be engaged but these sectors speak specifically to the health, dignity and empowerment of PLHIV.

In essence the leadership of PHDP must (as far as possible) be PLHIV-led through a multi-sectoral approach thus being inclusive of all stakeholders. Further to this the leadership must work on effective communication to ensure that its mandate is understood and implemented by all stakeholders. An effective secretariat has to be identified by the PHDP steering committee to assist in the dispensing of its duties.

Community Engagement

This speaks to the representation and inclusion (participation and involvement) of PLHIV on the national, sub-national and community levels. PLHIV must be engaged and must engage stakeholders in all sectors whether it is treatment, education, social protection and/or policy development. This means that the PHDP leadership should include PLHIV; however these leaders at all times must engage the PLHIV community. Engagement must take into considerations the various types of communities such as geographical, regional and even religious as well as sub-populations such as women, men, MSM, youth and PLHIV seniors. If this is not done the unique needs of all will not be accommodated for and in order to ensure health and dignity these must be accounted for. Inherent in community engagement is the

conversations around gender and equity. The voice of the community and all members of the community must be put forward when PHDP is being implemented across all sectors.

Community engagement will also push the leadership and governance of PHDP to integrate the excluded core components of social and economic support and measuring impact. Community engagement considers the social and economic support needed to create a completely healthy and dignified being. This engagement will direct how and where social and economic support is given.

Further to this measuring the impact of PHDP is hinged on community engagement. It will be the community which determines of PHDP is working especially across the service sectors such as health, education and social protection. This will inevitably lead to the reduction of stigma and discrimination.

PLHIV Health and Well-being using a Rights Based Approach

The concept that the health and wellbeing of the PLHIV is not one dimensional is at the core of this priority. It is based on clinical health and psycho-social wellbeing but also the enabling environments and policies in all sectors such as education and social protection. These ultimately contribute to the all-round health and wellbeing of PLHIV as PHDP values become systemic throughout all sectors. The understating of individual rights and being able to identify and address any violation of rights is important as PLHIV navigate the systems throughout the country. These concepts inevitably contribute to more systems which are friendlier to PLHIV and resulting in reduced stigma and discrimination across the board, thus allowing the PLHIV to attain their maximum health and well-being.

It should also be noted inherent in the health is the sexual and reproductive health rights and empowerment of PLHIV, especially women, who have faced stigma while trying to assert these rights. Sensitization and capacity building with PLHIV along with HCWs is important if this right is to be achieved especially considering as Jamaica is a signatory to several international treaties such as the SDGs, the 1995 Beijing Platform and the 2013 Montevideo Consensus, all which speak to sexual and reproductive health rights and gender equality.

In order to ensure the comprehensive well-being of PLHIV the core component of social and economic support has to be inter-woven in all PHDP and GIPA activities across all sectors. Economic support and social support are integral in the active and functional participation in the society by not just PLHIV but all citizens.

Monitoring and Evaluation

In order to measure the successes, strengths and weakness of streamlining PHDP into all aspects of the HIV response in Jamaica, strong M&E framework is essential. In fact the development of PHDP M&E Plan to lead the tracking and monitoring of PHDP and its related activities is strongly recommended. Currently there is very little monitoring of the programme and difficulty in measuring its outcomes.

Stronger leadership and coordination of PHDP should assist in monitoring PHDP be more effectively. The PHDP Steering Committee may have to set up a sub-committee or technical working group which is focused on monitoring and evaluation and ensure effective coordination. It is important that PHDP monitoring involves PLHIV as active participants, as well as, be aligned to other HIV strategic plans,

programmes and policies. Indicators which are developed should not be isolated and must include all aspects of PHDP from the use of the curriculum to the impact of the healthcare workers being guided by PHDP to the policies being developed or monitored, as well as, the monitoring and evaluation of community based support groups.

5.4 Goals

The aim of PHDP is to empower the PLHIV community to realise improvements in quality of life through dignity and access by addressing reduction of stigma and discrimination. In addition PHDP has an important role in helping Jamaica to achieve the 90/90/90 targets as the country tries to eliminate HIV. Therefore the goals for the PHDP Strategy are:

1. To utilize PHDP to reduce HIV Stigma and Discrimination
2. To advance Jamaica's Progress towards 90/90/90

5.5 Strategic Objectives

Strategic Objective 1: Strengthened leadership, management and coordination of the PHDP programme

Increased coordination and management will also require expanding coordinating roles beyond the GIPA Unit to allow for increased visibility of PHDP among civil society partners. Strengthening communication strategies with more involvement of PLHIV as 'messengers' further contributes to the meaningful involvement of PLHIV in HIV prevention, care, treatment, and support- a key aspect of PHDP. This also includes improved working relationships between all organizations which work to support PHDP and building the capacity of PLHIV leaders among these support groups and NGOs. To this end JN+ and its partners, such as the MOH/NFPB, need to provide and facilitate an environment for the dissemination and capacity building in GIPA and PHDP curriculum. Additionally, it is important to validate associations and support groups through governmental and political endorsements.

Table 2 Logic Framework with activities for Strategic Objective 1

Key Activities	Sub-Activities	Actors/Organizations
1.1 Create a multi-sectoral PHDP Steering Committee to guide, govern and lead the PHDP process in Jamaica.	1.1.1 Establish PHDP Steering by integrating or merging with	Lead Organizations • Enabling Environment Unit of NFPB

Key Activities	Sub-Activities	Actors/Organizations
	existing oversight committees in the HIV Sector.	• HIV/STI/Tb Unit of Ministry of Health • Jamaica Network of Seropositives
	1.1.2 Ensure steering committee is inclusive of PLHIV and other key stakeholder such as NGOs, IDPs, Private Sector and Government	Lead Organizations • Enabling Environment Unit of NFPB • HIV/STI/Tb Unit of Ministry of Health • Jamaica Network of Seropositives Partners/Stakeholders • PLHIV and other vulnerable populations • NGOs representing PLHIV and vulnerable population • The CCM or any other HIV coordinating body • IDPs • Private Sector Umbrella Groups • Government Ministries and Agencies of Health, Education, Labour and Social Security, Justice, Planning and Development • Faith Based Organizations
	1.1.3 Ensure that steering committee is multi-sectoral including health, education, social protection, justice and other sectors	
1.2 Operationalize PHDP/GIPA strategic plan across multi-sectors	1.2.1 Create and utilize an implementation guideline/plan	Lead Organizations • PHDP Steering Committee & Secretariat Partners/Stakeholders • PLHIV and other vulnerable populations • NGOs representing PLHIV and vulnerable population
	1.2.2 Conduct a multi-sectoral GIPA audit to ascertain the level of engagement in of various sectors in the	

Key Activities	Sub-Activities	Actors/Organizations
	country's HIV response	• Community Based Support Groups • The CCM or any other HIV coordinating body • IDPs • Private Sector Umbrella Groups • Government Ministries and Agencies of Health, Education, Labour and Social Security, Justice, Planning and Development • Faith Based Organizations
	1.2.3 Ensure that PLHIV locally, regionally and nationally lead and are integrally involved the process of implementation of the strategic plan	
	1.2.4 Ensure that a consensus is built around implementation plan from all stakeholders	
1.3 Scale up capacity building programmes to build PLHIV leadership to the highest level	1.3.1 Build the leadership capacity of PLHIV at the local, regional and national levels	Lead Organization • PHDP Steering Committee Partners/Stakeholders • PLHIV and other vulnerable populations • NGOs representing PLHIV and vulnerable population • Community Based Support Groups • Regional Health Authorities • IDPs
	1.3.2 Develop criteria and guidelines to identify and recruit potential PLHIV leaders at the national and sub-national levels	Lead Organization • PHDP Steering Committee
	1.3.3 Train all PLHIV leaders (across sectors) in full PHDP curriculum	Lead Organization • PHDP Steering Committee

Key Activities	Sub-Activities	Actors/Organizations
	1.3.4 Train PLHIV, key stakeholders and members of vulnerable communities to become PHDP trainers and facilitators.	Partners/Stakeholders • Enabling Environment Unit of NFPB • PLHIV and other vulnerable populations • NGOs representing PLHIV and vulnerable population • Community Based Support Groups • RHAs • IDPs

Strategic Objective 2: Integration of PHDP and its core components into existing and future programmes with key stakeholders in order to increase the physical and psycho-social wellbeing of PLHIV

A cadre of PLHIV exists who have the capacity to deliver PHDP curriculum, however, this needs to be expanded and more inclusive of stakeholders in other HIV NGOs as well as the MOH. The team should be able to deliver key PHDP components to health care workers and other social support individuals. A concerted effort should be made to further include PHDP in the training of all members of the multi-disciplinary treatment team as well as other sectors which have to work with persons infected and affected by HIV. These sectors include education, child protection services and social security. Further to this civil society partners should be encouraged to have their staff exposed to PHDP to ensure that linkages and retention in care are met.

Interventions also need to support mental health. Key modules associated with PHDP should be incorporated in any policy or programme which is geared towards clinical and psychological support of those infected or affected by HIV. Core curriculum modules include disclosure, treatment literacy, and advocacy and HIV knowledge. This objective will relies heavily on the input of the MOH and the Treatment Coordination Team working with JN+, the regions and other NGOs involved in treatment. Further to this PLHIV should be integral in any amendment to the curriculum or development of any policies which facilitate and enable healthy lives among the community.

Table 3 Logic Framework for activities for Strategic Objective 2

Key Activities	Sub Activities	Actors/Organizations
2.1 Create and improve partnerships with key PLHIV service delivery and support organizations to improve physical and psycho-social impact on PLHIV across the island	2.1.1 Include all NGOs/CBOs/ FBO's representing and providing services to PLHIV and vulnerable groups in decision-making and implementation of PHDP in existing or future programmes designed to improve physical and psycho-social well-being of PLHIV	Lead Organization • PHDP Steering Committee Partners/ Stakeholders • NGOs representing and serving PLHIV and vulnerable populations • Community Based Support Groups • RHAs • Enabling Environment Unit • HIV/STI/Tb Unit
	2.1.2 Identify and utilize the strengths of each PLHIV organization to improve physical and psycho-social well beings of PLHIV by streamlining PHDP into existing programmes, policies and activities.	Lead Organization • PHDP Steering Committee Partners/ Stakeholders • NGOs representing and serving PLHIV and vulnerable populations • Community Based Support Groups • RHAs
	2.1.3 Create MOUs (where necessary) with organizations representing and serving PLHIV and Vulnerable Populations in order to operationalize/streamline PHDP into their existing and/or new programmes	
2.2 Build the Capacity of key stakeholders and individuals involved in delivering healthcare and psycho-social services and support for PLHIV	2.2.1 Conduct PHDP Capacity Building workshops with HCW involved in delivering healthcare and psycho-social services for PLHIV	Lead Organization • PHDP Steering Committee Partners/Stakeholders • PLHIV and other vulnerable populations • HIV/STI/Tb Unit • NGOs representing and serving PLHIV and vulnerable populations • CBOs
	2.2.2 Train key stakeholders/partner organizations as trainers in PHDP curriculum	

Key Activities	Sub Activities	Actors/Organizations
		• Enabling Environment Unit-NFPB
2.3 Strengthen existing and create new support groups across the island by ensuring that PHDP core components are the foundation of the groups	2.3.1 Conduct an audit of existing PLHIV groups including supporting groups across all sectors	Lead Organizations • PHDP Steering Committee • NGOs, CBOs, FBOs serving and representing PLHIV and other vulnerable groups • RHAs
	2.3.2 Create guidelines to ensure that all new support groups and existing PLHIV NGOs and community workers are founded on PHDP core components	
	2.3.3 Conduct PHDP training with new support groups, their members and community workers and leaders using the PHDP curriculum	Lead Organizations • PHDP Steering Committee Partners/Stakeholders • NGOs, CBOs, FBOs serving and representing PLHIV and other vulnerable groups • EEHR Unit of NFPB • IDPs • PLHIV Leaders/Trainers • RHAs
	2.3.4 Provide mentorship for new support groups and old(established) support groups based on established community and support group guidelines	Lead Organizations • PHDP Steering Committee • NGOs representing PLHIV and other vulnerable populations (JN+, JCW) Partners/Stakeholders: • NGOs, CBOs, FBOs serving and representing PLHIV and other vulnerable groups • EEHR Unit of NFPB •
	2.3.5 Continuous provision of psycho-social support for PLHIV and PLHIV community workers and leaders	
2.4 Expand and improve the Community Facilitator programme	2.4.1 Build the capacity of PLHIV community leaders as Community Facilitators	Lead Organization

Key Activities	Sub Activities	Actors/Organizations
	2.4.2 Deploy Community Facilitators to work in more health sites as well as with community support groups	• PHDP Steering Committee • EEHR Unit of NFPB • NGOs serving and representing PLHIV Partners/Stakeholders • NGOs, CBOs, FBOs • RHAs • HIV/STI/Tb Unit • PLHIV and • IDPs
	2.4.3 Provide continuous psycho-social support for Community Facilitators deployed to health sites and other community based support groups	
	2.4.4 Develop PHDP low literacy IEC Material to be used by CFs and disseminated among PLHIV and other vulnerable groups	
	2.4.5 Incorporate PHDP principles in Quality Improvement Initiatives	Lead Organization • PHDP Steering Committee • EEHR Unit of NFPB • HIV/STI/Tb Unit, Treatment Section • IDPs
2.5 Facilitate the improvement of the social and economic management of PLHIV for their complete well-being	2.5.1 Identify the social and economic barriers and needs of PLHIV and key populations	Lead Organization • PHDP Steering Committee • Organization representing and serving PLHIV and vulnerable populations Partners/Stakeholders • Private Sector Organizations • Other Government Agencies and Ministries (MLSS, JBDC) • IDPs • NGOs, CBOs, FBOs serving and representing PLHIV
	2.5.2 Partner with private sector and other partners to identify job opportunities for PLHIV and other vulnerable groups.	
	2.5.2 Partner with private sector and/or government agencies to offer capacity building and skills training programmes for PLHIV and other vulnerable populations	
	2.5.3 Work with private sector, NGOs, Government and other stakeholders to	

Key Activities	Sub Activities	Actors/Organizations
	increase opportunities for access to support and resources for new and existing PLHIV entrepreneurs	• EEHR of NFPB
	2.5.4 Work with government agencies such as PATH and Poor Relief to develop social safety nets based on the needs of PLHIV and other vulnerable communities	

Strategic Objective 3: Strengthened PLHIV Human Rights and Rights Based Advocacy and Policy Development by integrating PHDP Core Components into multi-sectoral Policies and Programmes

A cornerstone of this objective is the focus on sectors outside of the health sector which enable the entire well-being of the individual living with HIV. This means the PLHIV must be involved in advocacy and policy development in sectors such as Education, Labour, Social Security, Child Protection and Justice. PHDP must be integrated into policies and programmes in these sectors. Additionally, as part of measuring PHDP, PLHIV capacity must be built in policy monitoring and development to ensure that these sectors are working towards improving the dignity of PLHIV and reducing stigma and discrimination. One key policy which PHDP should be streamlined into is that of the Occupational Safety and Health Act (OHSA). As part of its advocacy and policy monitoring the PHDP Steering Committee must work alongside the implementers of the OHSA and at the same time it must be properly monitored especially by the PLHIV community.

Governance and Management of PHDP has to ensure that sectors outside of health are engaged human rights, advocacy and policy and that PHDP is a part of these processes along with the engagement of PLHIV. An essential activity in this area is an audit of existing programmes to assess if any GIPA or PHDP activities in existence.

Table 4 Logic Framework of activities for Strategic Objective 3

Key Activities	Sub Activities	Actors/Organizations
3.1 Integrate PHDP into policies and programmes across all government sectors especially education, labour, child protection and social protection and justice	3.1.1 Sensitize key personnel in other government sectors outside of health on PHDP core components.	Lead Organization • PHDP Steering Committee Stakeholders/Partners • Government Agencies in Education, Labour, Child Protection and Justice • NGOs, CBOs and FBOs representing and serving PLHIV • EEHR of NFPB • Private sector umbrella organizations • IDPs
	3.1.2 Work with sectors outside of health to develop/adapt policies which are directed by the needs of PLHIV	
	3.1.3 Facilitate the dignity of PLHIV by ensuring that policies are implemented across all sectors are directed by PHDP core components and PLHIV.	
	3.1.4 Recruit and select PHDP trained leaders for deployment at the national and sub-national levels with key stakeholders from all sectors which have PLHIV programmes and activities.	
	3.1.5 Build the knowledge and capacity around Human Rights and Advocacy in Policy Development among PLHIV and PLHIV community Leaders	
3.2 Increase PLHIV knowledge around human rights and advocacy as it relates to reporting and redress	3.2.1 Sensitize PLHIV on Human Rights and Advocacy using the modules from the PHDP training curriculum	Lead Organization • PHDP Steering Committee Stakeholders/Partners • Government Agencies in Education, Labour,
	3.2.2 Build the capacity of PLHIV and other	

Key Activities	Sub Activities	Actors/Organizations
	vulnerable populations around the issues of reporting and redress	Child Protection and Justice • NGOs, CBOs and FBOs representing and serving PLHIV • EEHR of NFPB • Private sector umbrella organizations • IDPs
	3.2.3 Sensitize PLHIV to existing policies and advocacy agendas which affect them across various sectors	
	3.2.4 Sensitize PLHIV about reporting and redress systems and mechanisms	
	3.2.5 Develop literacy level appropriate PHDP Advocacy and Human Rights IEC Material	
	3.2.6 Empower PLHIV Community Leaders such as CFs to act as representatives as part of report and redress mechanisms	

Strategic Objective 4 – Improved Monitoring and Evaluation of PHDP Programming ensuring its alignment to national strategic plans and policies and programmes.

Improving M&E of PHDP aims to ensure on-going evaluation of the PHDP, determine its effectiveness and answer questions such as do interventions that target PLHIV effectively reduce HIV risk behaviours or do they improve the psycho-social and economic being of the individual? Currently, there is not enough evidence to determine effectiveness of the programme and answer this question however there are already specific indicators available for reporting which can be used to help monitor PHDP and its streamlining. Some indicators in the national HIV M&E Plan which can be considered related to PHDP outcomes and activities are:

- Percentage of people living with HIV and on ART, who have a suppressed viral load at 12 months (<1000 copies/ml) Percentage of newly diagnosed people linked to HIV care (individual linkage)
- HIV O-1(M): Percentage of adults and children with HIV, known to be on treatment 12 months after initiation of antiretroviral therapy.
- HIV O-12: Percentage of people living with HIV and on ART who are virologically suppressed (among all those currently on treatment who received a VL measurement regardless of when they started ART)

These are specific to PHDP outcomes such as linkage to care, adherence, retention and viral suppression. However, in order to be used in evaluating PHDP, treatment sites will have to be aware of the indicators and be able to stratify results based on PHDP involvement or engagement with persons trained under PHDP.

Indicator should also include those which measure psycho-social impact of the programme. Other indicators which can be used to measure PHDP and its overall implementation processes include but are not limited to the indicators suggested below. They only serve as suggestions for the implementation phase of the PHDP strategic plan. The suggested indicators are:

Indicators

1. # of new PLHIV trained and capacity built in PHDP
2. # new PLHIV leaders
3. # of CFs deployed at Health sites
4. # of HCW trained in PHDP
5. # of NGOs represented in PHDP training workshops
6. # of NGOs incorporating PHDP curriculum in their support groups and prevention activities
7. # of support groups formed which include PHDP in their processes.
8. # of PLHIV reporting increased CD4 counts
9. # PLHIV reporting decreased viral loads
10. Increased #s of PLHIV being retained in care after being exposed to CFs
11. X% of PLHIV in leadership positions in the HIV response

For strong M&E processes, coordination of the PHDP leadership needs to be strong. A technical working group or an M&E subcommittee will have to be pursued in order to ensure M&E of the highest quality is implemented for this plan. Further to this capacity of all partners, key populations and stakeholders must be built in M&E. This ensures continuous monitoring along the spectrum of all key actions. It also speaks to the inclusion of all, especially that of the PLHIV in the direction of PHDP and the HIV response.

Table 5 Logic Framework for activities for Strategic Objective 4

Key Activities	Sub Activities	Actors/Organizations
4.1 Develop a monitoring and evaluation plan for the mainstreaming of PHDP into existing programmes and policies.	4.1.1 Develop/Amend indicators to measure PHDP activities in the health sector which are aligned to broader national outcomes and indicators (HIV and SRH)	Lead Organization • PHDP Steering Committee • PHDP M&E Working Group Partners and Stakeholders • Organizations representing PLHIV and other vulnerable groups • IDPs • RHAs
	4.1.2 Develop monitoring tools to track the integration PHDP on the health, HIV and SRH sectors ensuring that PLHIV and other	

Key Activities	Sub Activities	Actors/Organizations
	vulnerable groups are included in the process	• Government Agencies and Ministries • CBOs • FBOs • NGOs
	4.1.3 Develop/Amend monitoring tools to track the integration of PHDP on pyscho-social well-being ensuring that PLHIV and other vulnerable groups are included in the process	
	4.1.4 Develop tools to monitor and track PHDP capacity building workshops based on PHDP Curriculum.	
	4.1.5 Develop tools and monitoring systems to track the community facilitator programme across the health sector and in community support groups ensuring that PLHIV and other vulnerable groups are included in the process	
	4.1.6 Develop/Amend tools for policy monitoring ensuring that PLHIV and other vulnerable groups are included in the process	
4.2 Build the capacity of PLHIV, vulnerable populations and key stakeholders in monitoring and evaluations	4.2.1 Build the capacity of PLHIV and PLHIV leaders around policy monitoring	Lead Organization • PHDP Steering Committee Partners/Stakeholders • NGOs, CBOs, FBOs serving PLHIV and other vulnerable populations • IDPs • Government sectors • HIV/STI/TB Unit • Enabling Environment Unit- NFPB • RHAs
	4.2.2 Sensitize PLHIV and other vulnerable groups to monitoring tools and indicators	
	4.2.3 Build the capacity of Community Facilitators to use monitoring tools and to create reports	
	4.2.4 Sensitize key stakeholders across all sectors on PHDP	

Key Activities	Sub Activities	Actors/Organizations
	indicators and monitoring and evaluation tools	
	4.2.5 Build the capacity of key multi-sectoral stakeholders in monitoring PHDP streamlining and integration.	

6. Partner Agencies & Stakeholders

In order for PHDP to have the impact which it is set out to do it will ensure that all stakeholders and organizations are involved. The list below is not meant to be exhaustive but are key stakeholders in the success of PHDP. The list must include organizations outside of the health sector is PHDP is to be impacting and is to ensure the dignity of PLHIV.

The stakeholders can be split into several groups. These include HIV organizations, Governmental Organizations, Agencies of the Ministry of Health as well as International Organizations.

HIV Organizations:

These are entities which serve the PLHIV community directly. Many of these organizations are non-governmental and provide support and care services. In some cases some are led by PLHIV as with JN+ and JCW+ and include interventions which are more than related to treatment and support. Additionally, these organizations serve sub-populations such as women, MSM, transgender and youth. They also serve the community in different geographical areas. Also included in this list are new support groups which are being formed across the island which are linked to geographical regions or are faith based.

This plan encourages the expansion of support groups therefore the list below is not exhaustive and can be amended when necessary.

- Jamaica Network of Seropostives
- Jamaica Community of Positive Women
- Eve for Life
- Colour Pink
- Jamaica AIDS Support for Life
- AIDS Healthcare Foundation
- Support Groups (not affiliated with any of the above NGOs)
- Faith Based Groups

Ministry of Health and its Agencies/Departments

These speak to the government agencies of the Ministry of Health who provide care and support for PLHIV and who are integral in directing treatment and care protocols. The organizations can also assist in moving the PHDP agenda and their staff should be exposed to training and capacity building in PHDP.

- Ministry of Health
- HIV/STI/Tb Unit
- National Family Planning Board
- Regional Health Authorities
- University Hospital of the West Indies/CHARES

Other Government Ministries and Agencies

These are government ministries and agencies which deal directly and indirectly with HIV. The workings of these sectors enable the lives of PLHIV some way somehow, whether through social protection, education or accommodation for work, or in the case of some providing redress and recourse if acts of discrimination or committed. These ministries/agencies must be engaged in PHDP and in the case of some full PHDP capacity building is necessary.

- Ministry of Education
- Ministry of Labour and Social Security
- Ministry of Justice
- Child Protection and Family Services Agency
- Planning Institute of Jamaica
- Ministry of Local Government

International Development Partners

These are partners which provide technical and financial resources to assist in the implementation of PHDP across all sectors. The list below is not meant to be exhaustive but can be expanded as necessary. It is important though for the leadership of PHDP to maximize on the strengths of each IDP especially as it relates to its target populations and its objectives

- Health Policy Plus
- FHI 360/Linkages
- I-TECH
- UN Agencies
- USAID
- AIDS Healthcare Foundation

7. Beneficiary Populations

Positive, Health, Dignity and Prevention speaks to the health and dignity of individuals living with HIV. As part of the mainstreaming of PHDP into existing HIV programmes it is imperative that all the needs of the various sub- communities within the PLHIV community are accounted for and are a part of any of the programmatic and policy processes.

This therefore means that the involvement of various populations must be taken into consideration when mainstreaming PHDP and the PHDP curriculum must address any nuanced issues associated with the sub-populations. PLHIV from various sub-populations must also be involved in the PHDP leadership both at a national and sub-national level.

The policy frameworks must address the equity which is needed to ensure that PLHIV from sub-populations are not only involved in the decision making processes but are being served to the highest quality which will ensure their total health and well-being.

An important aspect of this is the acknowledgement that each sub-population has varying needs in order to ensure their health and well –being is at optimum. Therefore, governmental organizations, NGOs and community based support groups must facilitate these nuances whether during formation or through the continuum of services they provide.

Key beneficiary populations include:

1. General Population PLHIV
2. Women
3. Men
4. Youth
5. Senior PLHIV
6. Teen Mothers
7. MSM
8. Transgender
9. Female Sex Workers
10. Prisoners
11. Homeless Drug users

8. Resource Mobilization

In order for the plan to implemented resources will have to be mobilized. Streamlining PHDP into existing government and/or non-governmental programmes may assist in the finding resources for implementation. However, from the impact evaluation the per unit head cost for the capacity building workshops is high. Alternate methods for capacity building workshops need to be assessed.

The PHDP Steering Committee may have to approach technical and resource partners who typically do not contribute to the HIV response, such as private sector. Additionally models using the social enterprise may have to be assessed to see its value in resource mobilization of PHDP implementation.

Annex 1- Logical Framework Goals and Priorities

Table 6 Logical Framework Goals & Priorities

Narrative Summary	Objectively Verifiable Indicators	Means of Verifications	Assumption/Possible Risk
Goal 1: To utilize PHDP to reduce HIV Stigma and Discrimination	1. Decreased reports in HIV Stigma and Discrimination by PLHIV 2. Increased access to health and social services by PLHIV	1. Stigma Index Report among HIV 2. Number of reports to Redress systems 3. Timely reports from support groups 4. Stigma Study amongst general population and/or health care workers 5.	PLHIV are empowered to understand stigma, human rights, discrimination and have the ability and access to report HIV related Stigma and Discrimination
Goal 2: To advance Jamaica's Progress towards 90/90/90	1. More PLHIV being retained in care 2. More PLHIV on medication 3. More PLHIV with Viral Suppression	1. Routine Surveillance Reports 2. Reports from Treatment Unit 3. Reports from RHAs	Data collection and monitoring tools around treatment and care incorporates PHDP activities and are robust
Priority 1: Governance and Leadership- strengthen the coordination, management and leadership of PHDP	1. PHDP Multi-sectoral Steering Committee 2. Cadre of PHDP trained PLHIV leaders at national and sub-national levels involved in PHDP Operationalization	1. Guiding Document or TOR of Steering Committee 2. Minutes of Steering Committee 3. Administrative Reports	Inclusion of all sectors will take strong leadership and must include effective communication.
Priority 2: Community Engagement- the involvement of PLHIV in all aspects of PHDP Operationalization	1. PHDP integrated into policies and programmes across all government sectors especially education, child protection and social protection	1. Policy Documents 2. Minutes of Policy Processes 3. Administrative Reports from PHDP Steering Committees	PLHIV are empowered and that PLHIV and community players have increased their capacity in Programme Management, in

	2. PLHIV involved in determining HIV policy and advocacy agenda for the country 3. Community/Faith Based support groups across the island maintained, developed and guided by PHDP principles 4. Programmes developed directed by PLHIV and vulnerable populations	4. Project /Programme Documents 5. Reports from Community Based Support/Faith Based Group Reports	particular the area of monitoring and evaluation.
Priority 3: PLHIV Health and Well-being using a Rights Based Approach- ensuring the holistic approach to health including Sexual and reproductive health and psycho-social well-being	1. Cadre of Healthcare and Community workers understanding and using PHDP principles 2. More PLHIV accessing quality health services 3. More PLHIV reporting good psycho-social health 4. More PLHIV accessing socio-economic empowerment opportunities	1. PHDP Capacity Building Knowledge and Skill Assessments 2. Monthly surveillance reports 3. PLHIV Stigma Study 4. Bio-behavioural studies 5. Administrative reports 6. Social Worker and Psychology Monthly Reports	The concept of PHDP will have to be incorporated in treatment, care and support from the on-set of diagnosis.
Priority 4: Monitoring and Evaluation	1. A PHDP Monitoring and Evaluation Plan 2. Development of PHDP Indicators for the Health Sector 3. Development of PHDP indicators for Human Rights, Advocacy and Policy Sector 4. A cadre of PLHIV leaders who can	1. PHDP Monitoring and Evaluation Plan 2. Technical Working Group Meeting Reports 3. Administrative Reports	This requires the development of an Monitoring and Evaluation Plan the ability of stakeholders to be included in the monitoring of PHDP objectives

	monitor PHDP activities

Annex 2- Sample Implementation Plan

Strategic Objective	Activity/Activities	Organization Responsible	Contact Person from Organization	Time Period of Activity	Deliverable	Expected Outcome
1.	1.					
	2.					
	3.					
2.	1.					
	2.					
	3.					