PAHO/WHO Jamaica (Draft as of March 29, 2017: Chapters 1 and 2)

2017-2021

**PAHO/WHO Country Cooperation Strategy (CCS), Jamaica**



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### Foreword

### Abbreviations

BWP Biennial Work Plan

CARICOM The Caribbean Community

CCH Caribbean Cooperation in Health

CCS Country Cooperation Strategy

CO Country Office

EU European Union

FA Focus Areas

FAO Food and Agricultural Organization

FCTC Framework Convention on Tobacco Control

FNS Food Nutrition and Security

GDP Gross Domestic Product

GDI Gender Development Index

HiAP Health in All Policies

HIA+17 Health in The America’s 2017

HIV Human Immunodeficiency Virus

HDI Human Development Index

IDB Inter –American Development Bank

IHR International Health Regulations

LGBT Lesbian, Gay, Bisexual, Transgender

MDGs Millennium Development Goals

MOH Ministry of Health

MSM Men who have sex with Men

NCDs Noncommunicable Diseases

NGO Nongovernmental Organization

NHPSP National Health Policy and Strategic Plan

ODA Official Development Assistance

PAHO/WHO Pan American Health Organization/ World Health Organization

PHC Primary Health Care

PIOJ Planning Institute of Jamaica

PWR PAHO/WHO Representative

SDGs Sustainable Development Goals

STATIN Statistical Institute of Jamaica

SP Strategic Priority

TC Technical Cooperation

THE Total Health Expenditure

UH Universal Health

UHC Universal Health Coverage

UNAIDS The Joint United Nations Programme on HIV/AIDS

UNDP United Nations Development Programme

UNFPA United Nations Population Fund

UNICEF United Nations Children’s Fund

UNIFEM United Nations Development Fund for Women

UN MSDF United Nations Multi-Country Sustainable Development Framework

USAID United States Agency for International Development

WHO World Health Organization

### Executive Summary

## 1. Introduction

### 1.1 Overview of the PAHO Policy Framework

The PAHO/WHO Country Cooperation Strategy (CCS) for Jamaica provides a clear understanding of the medium term vision that will guide the implementation of the Organization’s technical cooperation at the national level. Through this four-year CCS for Jamaica, PAHO/WHO will continue to support national health policies, strategies and plans while working and collaborating with other United Nation (UN) and development partners to advance universal health and sustainable development.

The focus of PAHO/WHO’s technical cooperation (TC) at country level is to protect and safeguard past achievements in health and to face new challenges especially in the context of achieving the Sustainable Development Goals (SDGs) (see Annex 1). This TC is obtained through:

* Support for achieving national, sub regional, regional and global health goals;
* Strengthening the capacity of the country to influence and take advantage of international cooperation in health;
* Giving health a prominent place in national development plans;
* Reflecting the interests and perspectives of the country in the global development agenda, including the governing bodies - World Health Assembly (WHA) and Directing Council (DC).

### 1.2 Country Context

##### **Geography of Jamaica**

**Figure 1.**



**Source:** www.geometry.net

Jamaica is the largest English-speaking and third largest island in the Caribbean located 150 km south of Cuba and 160 km west of Haiti. It has a land mass of 11,424 km2 – 82 km wide by 234 km long. Its topography is made up of mountain ranges with the highest point being the Blue Mountain Peak at 2,256 metres in the north east, a limestone plateau and coastal stretches of clear, sandy beaches. The country is divided into 3 counties and further divided into 14 parishes, with the capital city Kingston located on the south-east coast and Montego Bay, the second city, on the north-west coast. It has a tropical climate, which is influenced by the sea and the northeast trade winds making it favourable for tourism and agricultural production. Its people can be described as multi-ethnic with the majority of the population being of African descent with a smaller portion of the population being of European, East Indian and Chinese origin.

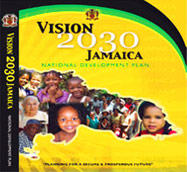
***“Jamaica is known worldwide for its strong sense of identity, expressed through its music, sport and rich cultural mix, which enables the country’s influence to extend far beyond its shores.”* Source: Vision 2030, National Development Plan, Jamaica.**

### 1.3 The CCS Development Process

This 2017-2021 CCS for Jamaica comes at a critical time as the Ministry of Health continues to face the emergence of new diseases (Ebola, Chikungunya and Zika). It encourages Jamaicans to pursue a healthy lifestyle, copes with the impact of violence and trauma on health services while striving to build a health care system that delivers universal health care to all.[[1]](#footnote-1) The development of the CCS was based on a consultative and participatory process that included an evidence–based, results focused, approach which relied on political will, accountability and strengthening links with other sectors. It was also built on the concept of the Post 2015 agenda of *“leave no one behind”* to ensure equitable approaches are used to address the needs of the most vulnerable. It was led by the PAHO/WHO Representative for Jamaica, Bermuda and the Cayman Islands who worked in collaboration with a CCS Working Group that included both PAHO Technical staff and representatives from the Ministry of Health, the University of the West Indies and civil society. The process included:

**1. The review of key documents:**

**a. National documents and frameworks** -

* **Ministry of Health Strategic Business Plan (2017-2020)** – The 3-year plan is aligned with the National Development Plan – Vision 2030 and outlines the Ministry’s strategies for delivering health care services that are aligned with the needs of the population. It emphasises the strengthening of existing programmes and the execution of new initiatives to reduce and mitigate the impact of diseases such as non-communicable and communicable diseases, and improve health outcomes.[[2]](#footnote-2)
* **National Development Plan** - [Vision 2030 Jamaica](http://www.vision2030.gov.jm/Overview/Vision)[[3]](#footnote-3) - The National Development Plan provides a strategic road map to guide the country to achieve its goals of sustainable development and prosperity by 2030. It is aligned with the Sustainable Development Goals (SDG) that integrates the standards and principles of human rights – participation, non-discrimination and accountability. The vision of this National Development Plan is to make *“Jamaica, the place of choice to live, work, raise families and do business*”.[[4]](#footnote-4) The Plan has 4 national goals that overlap (Annex 1):
  + Jamaicans are empowered to achieve their fullest potential (this goal emphasises health and is linked to the *National Outcome 1- A Healthy and Stable Population*) .
  + The Jamaican society is safe, cohesive and just
  + Jamaica’s economy is prosperous
  + Jamaica has a healthy natural environment.

National Outcome # 1 of the Plan is aligned to SDG Goal # 3 (Ensure healthy lives and promote well-being for all at all ages and is a cross-cutting theme in goals), #2 (End hunger, achieve food security and improved nutrition and promote sustainable agriculture), and #6 (Ensure availability and sustainable management of water and sanitation for all).

* **The 3rd Medium Term Socio-Economic Policy Framework (MTF) 2015 - 2018** builds on the previous gains and outlines the priorities for achieving the goals and outcomes of the long-term development plan.[[5]](#footnote-5) There are 4 medium term themes under MTF 2015 – 2018, that will move Jamaica towards *Achieving Inclusive Growth and Sustainable Development*: development and protection of human capital; national security and justice; economic stability, growth and employment; and environmental sustainability and climate change response.

**b. Regional documents and frameworks** -

* CARICOM documents mainly the Caribbean Cooperation in Health IV;
* PAHO Strategic Plan 2014-2019, *“Championing Health: Sustainable Development and Equity;*
* PAHO Health in the Americas 2017 Jamaica Country Chapter;
* PAHO Strategy for Universal Access to Health and Universal Health Coverage;
* PAHO Health in All Policies;
* UN and development agency documents and frameworks such as the United Nations Multi-Country Sustainable Development Framework in the Caribbean (UNMSDF).

**2. Stakeholder Survey** - the results of an online survey with key national stakeholders that requested feedback on PAHO/WHO technical cooperation over the last 5 years;

**3. National Consultation** - the holding of a multi-sectoral national consultation to identify the CCS priorities and FAs based on the health needs and priorities.

The CCS was jointly signed by the Ministry of Health, Jamaica and the Director of PAHO. The SPs and FAs will be aligned with the PAHO biennial workplan (BWP) which funds most of the activities at the country level.

## 2. Health and Development

### 2.1. Political, Macroeconomic and Social context

##### **2.1.1 Political**

Jamaica gained its political independence from England on 6 August, 1962 becoming a parliamentary democracy based on a system of representative government. The Constitution of Jamaica (1962) is primarily modelled on the Westminster-Whitehall system of government; the British monarch is represented in the country by a Governor General, to whom the Constitution of Jamaica grants limited powers. The Parliament of Jamaica is the legislative branch of the government of Jamaica and it consists of two Houses - an appointed Senate and an elected House of Representatives. The maximum life of the Parliament is five years at the end of which it must be dissolved.[[6]](#footnote-6)

The Ministry of Health (MOH) is the Government organization whose mandate is “*To ensure the provision of quality health services and to promote healthy lifestyles and environmental practices”.* Since Independence, Jamaica has had a number of Ministers of Health, who have implemented significant health programmes that have contributed to the growth and development of the health sector.

##### **2.1.2 Economy**

Jamaica continues to earn most of its foreign exchange from tourism, remittances, and bauxite/alumina. Remittances and tourism each account for 30% of GDP, while bauxite/alumina exports make up roughly 5% of GDP.[[7]](#footnote-7) The tourism industry is Jamaica’s primary contributor to its Gross Domestic Product (GDP). The agricultural sector also makes significant contributions to Jamaica’s economy with coffee, cocoa, spices, sugar cane and bananas being some of the main export crops, while yams, sweet potatoes, corn and pumpkins are grown mainly for the domestic market.[[8]](#footnote-8)

Jamaica’s growth and the macroeconomic situation operate within the context of the Jamaica National Development Plan - [Vision 2030](http://www.vision2030.gov.jm/National-Development-Plan). [[9]](#footnote-9) Jamaica is classified by the World Bank as an upper middle income country and for decades the country has struggled with low growth, high public debt and many external shocks that have weakened the economy. However, with the implementation of a comprehensive reform programme, the 2016 Doing Business Report, ranked Jamaica among the top ten improvers worldwide and the highest ranked Caribbean country in 2015.[[10]](#footnote-10)

In 2015, Jamaica recorded improvements in most of the indicators for economic and social development. It also represented the 3rd of the four-year Extended Fund Facility (EFF) of the International Monetary Fund (IMF) Agreement, with the implementation of the required Economic Reform Programme (ERP) to reduce debt to GDP from 140% to 95% in 7 years and the public sector wage bill as a percentage of GDP to 9% by fiscal year 2015/16.[[11]](#footnote-11) Jamaica also recorded its 3rd consecutive year of growth with a real value-added growth of 0.80% in 2015. At the end of 2015, the per capita GDP expressed in United States dollars was US$5,114.23 compared to US$5101.12 recorded 2014.[[12]](#footnote-12) The actual rate of inflation declined to 3.7% in 2015 relative to 6.4% in 2014. The Total Health Expenditure (THE) as a percentage of GDP fluctuated between 5.2 percent and 5.9 percent respectively from 2008 to 2014.

##### **2.1.3 Social**

The social context in which people live can have an impact on their health. The conditions in the environment where people live, learn, work, and play can affect a wide range of health risks and outcomes. These conditions are called the social determinants of health.

**Poverty**

In 2012, the Poverty Headcount Ratio of persons living below the poverty line in Jamaica was reported as 19.9%.[[13]](#footnote-13) With poverty prevalence increasing, special emphasis was placed on the development and monitoring of a revised National Policy on Poverty and a Strategic Poverty Programme in 2013. A new Social Protection Strategy was implemented to deliver appropriate interventions, towards greater sustained outcomes for the poor and vulnerable with a Social Safety Network Reform programme to enhance empowerment. In December 2016, the Planning Institute of Jamaica developed a ‘Green Paper’ entitled the National Policy on Poverty and the National Poverty Reduction Programme.[[14]](#footnote-14) Both the proposed National Policy and Programme were linked to Vision 2030 Jamaica for the delivery of the outcome - Effective Social Protection.

The “Green Paper” indicated that the poverty rates in the rural areas tended to be higher than the national poverty rates and in general, the rates for men were slightly higher than those for women. However, those households headed by women had higher poverty rates than those headed by men.[[15]](#footnote-15) Among the main issues identified as the determinants of poverty were:

* low educational attainment levels
* low income earning capability
* inability to access basic social services
* lack of economic opportunities leading to underemployment, unemployment and low wage employment
* poor rural development impacting the opportunities and livelihoods of rural households
* high levels of risks due to natural hazards[[16]](#footnote-16)

**Housing**

The last Population and Housing Census 2011 revealed that 54.0% of the population resided in urban areas, reflecting a 7.2% increase compared to the previous census in 2001. In 2015, 24.6% of the population lived in Kingston and St. Andrew and 19% in St. Catherine. The Draft National Housing Policy prepared in 2011 is being reviewed to include recommendations on development and improvement of informal settlements. The rapid growth of “Squatting” is of particular concern in Jamaica especially in environmentally sensitive areas such as watersheds, flood plains and lands vulnerable to landslides. Conservative estimates put the incidence of squatting at between 5 to 20 % of the housing stock.[[17]](#footnote-17) In 2016, the National Housing Trust introduced new loan and mortgage initiatives that targeted low-income earners.

###### **Education**

**The Jamaican Foundation for Lifelong Learning (JFLL) reported that the country’s adult literacy rate in 2016 was 87%. [[18]](#footnote-18)** In 2015, the gross enrollment rates for pre-primary, primary, secondary and tertiary schools in the public and private education systems were 99.8, 99.4, 97.3 and 28.3 % respectively.[[19]](#footnote-19)

Current legislation provides for free education from early childhood through primary school. Tertiary education is provided through five universities and a variety of community and teachers’ colleges, some state-owned and some privately funded. Universities include the University of the West Indies Mona Campus, The University of Technology, the College of Art, Science and Technology, the North Caribbean University, and the University College of the Caribbean. The education sector continues to experience some challenges which include: males performing below females at the secondary and high education levels; violence in schools especially at the secondary level; and competing national priorities for resource allocations.

The Education Sector Reform Programme was expanded in 2009 to become the Education System Transformation Programme (ESTP), which represents a comprehensive set of actions designed to improve standards of performance and greater accountability at all levels of the education system. The programme thereby acts as a catalyst for Jamaica’s growth and development.

###### **Employment**

As of October 2016, the Labour Force Survey Employment Rate was 87.10% and the Labour Force Survey Unemployment Rate was 12.90.[[20]](#footnote-20) The youth unemployment rate in 2016 was 29.2% with the average unemployment rate for women being almost double that of the men 18.6 % versus 9.6%.[[21]](#footnote-21) Labour market reform remains a priority. In 2016, 1.3 million persons were employed, but less than 500,000 Jamaicans are on the tax register as a large section of Jamaica’s economy is informal.[[22]](#footnote-22)

### 2.2 Health Status of the Population

The Ministry of Health (MOH), Jamaica is committed to providing quality healthcare and improving access to health services for the population despite the socio-economic challenges facing the country. The implementation of Universal Health continues with the focus on health system strengthening, primary health care renewal and improved access to services. The MOH regards good health as a concern for which the entire society should take responsibility. [[23]](#footnote-23)

##### **2.2.1 Demographic Trends**

Jamaica’s estimated population in 2015 was 2,728,907 of which 49.5% were males and 50.5% were female.[[24]](#footnote-24) In the same year there were 37,556 births and 17,327 deaths. The 50-59 and 60 and over age groups showed largest percentage increase of 15% (278,403) and 10% (341,071) respectively.[[25]](#footnote-25)

In 2015, the percentage of working-age population was 48.63 %. (See Figure 2: Population Pyramid, Jamaica – 2015, and 2030 -projections).

**Figure 2.**

The life expectancy at birth reported in the PAHO Core Indicators 2016 was 75.9 (73.6 for males and 78.4 for females).[[26]](#footnote-26) The crude birth rate for 2015 was 13.78 births per 1,000 population.[[27]](#footnote-27) Between 20102014, the largest decline was recorded for mothers under 20 years old (13.8%) due to a reduction in the number of births.

In 2014, a total of 19,557 deaths were reported; this is an increase of 12.7% over 2013. The leading cause of death for 2014 was reported to be “Diseases of the Circulatory System” which claimed 6,476 lives: 3,182 men and 3,294 women.[[28]](#footnote-28) The Infant Mortality Rate (IMR) (<1 year old) was 17.4 per 1,000 live births and the Child Mortality Rate (< 5years old) 19.1 per 1,000 live births in 2011.[[29]](#footnote-29) For children under 5 years - male and female - respiratory and cardiovascular disorders specific to the peri-natal period were the leading causes of death from 2011 – 2014.

High levels of migration continue to impact population size and structure. In 2013, a total of 24,744 persons migrated to the United States, the United Kingdom and Canada. The population is also showing signs of ageing based on the current trend in the fertility and mortality patterns.

##### **2.2.2 Noncommunicable and Communicable Diseases**

###### **Noncommunicable Diseases**

Jamaica is experiencing an epidemiological transition with the burden of communicable diseases declining and noncommunicable diseases (NCDs) increasing at a significant rate. NCDs and their related risk factors are a major public health challenge that can undermine the social and economic development in Jamaica. In 2014, cerebrovascular diseases, hypertensive diseases and diabetes mellitus were among the 5 leading causes of deaths for both males and females. . NCDs accounted for 12,573 (67%) of deaths in this population. Most cancer deaths in men were from cancer of the prostate (676) and for women, cancers of the breast (393) and the cervix uteri (167).[[30]](#footnote-30)

These diseases share four common behavioural risk factors: tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol. Preliminary data from the National Household Survey conducted among 4263 12-65 year olds, in 2016 reported that 75% had used alcohol, 30% had used cigarettes and 28% had use marijuana (ganja).[[31]](#footnote-31) In the latest Health and Lifestyle Survey (JHLS II) conducted in 2008 46% of the adult population was classified as having low physical activity or being inactive.[[32]](#footnote-32) In 2010, the levels of overweight and obesity were high in Jamaica and more prevalent in women than men. The age-standardized prevalence of overweight in adults over 18 years was estimated as 48.7% in men, 63.6% in women and 56.3% in both sexes in 2010.[[33]](#footnote-33) It is estimated that 3 out of 4 students drink a soda (carbonated beverage) one or more times per day. The GOJ is considering a fair approach to regulate and discourage the overconsumption of sweetened drinks and other products with high sugar content.[[34]](#footnote-34)

In late 2016, the Ministry of Health launched JHLS-III with the goal of finding out how many Jamaicans are affected by:

* chronic diseases such as diabetes, hypertension, heart disease, asthma, kidney disease, and cancer, or have risk factors for these conditions;
* accidents and violence (intentional and unintentional injuries);
* chikungunya, Zika and other mosquito-borne infections.

Over the years, the Ministry has implemented other programmes and initiatives to prevent and control the spread of NCDs, the most significant being the development of the *National Strategic and Action Plan for the Prevention and Control of Non-communicable Diseases (NCDs) 2013-2018*. The National Plan provides a framework and road map for national actions to combat noncommunicable diseases and injuries and their risk factors in Jamaica within the context of the socioeconomic, cultural and development agenda.[[35]](#footnote-35) Efforts to reduce risk factors have included the implementation of 3 of the 4 tobacco demand reduction interventions under the Framework Convention on Tobacco Control (FCTC) -taxation policies, smoke-free environments and health warnings. Jamaica also developed [Public Health (Tobacco Control) Regulations, 2013](http://www.japarliament.gov.jm/attachments/412_The%20Public%20Health%20(Tobacco%20Control)%20Regulations,%202013.pdf).

**Mental Health and Substance Abuse**

Since the 1960’s, Jamaica has continued the transition from a ‘psychiatric hospital’-focused mental health service to one that is community-based, in partnership with all sectors. The emphasis is on the promotion of mental health, early diagnosis and treatment of mental disorders (across age groups), and psycho-social and vocational rehabilitation. The Mental Health Programme/Policy Initiative promotes good mental health, prevention of mental health disorders and the provision of a comprehensive range of services across the lifespan.[[36]](#footnote-36) Since 2010, there has been an 8.3% reduction in the number of patients seen in the Community Mental Health Service with 18,991 patients reported seen in 2015. For child and adolescent mental health services, 9000 patients were seen in 2015. The main diagnoses included major depression, anxiety disorders, learning disorders and child abuse.[[37]](#footnote-37)

The National Secondary School Report conducted in 2013 reported that of those surveyed 20.7% of the secondary students had used marijuana and the average age of first use was 12 years old.[[38]](#footnote-38) In the 2016 National Sectorial Presentation for Health it was reported that 90% of the adolescents seen in the NCDA’s drug treatment programme were referred due to problems associated with marijuana use. The Amendments to Jamaica’s Dangerous Drugs Act in 2015 makes the possession of two ounces or less of marijuana a “ticketable and non-arrestable” offence. The impact of this Amendment on the health services will need to be monitored.

**Violence and Accidents**

**Violence**

In 2015, the total number of reported crimes declined by 39.4% but murders increased by 20.1%.[[39]](#footnote-39) Violence is the second leading cause of death in the age group 35 to 45, accounting for 1 out of 10 deaths in this age group.[[40]](#footnote-40) The 5th most prevalent cause of death in Jamaica is “Assault”, which is the intentional use of violence on the physical person resulting in death. Approximately one third of Accident and Emergency (A&E) visits were for violent intentional injuries, mainly blunt force trauma, lacerations and stabbings, which place a burden on the health system.[[41]](#footnote-41)

The [National Security Policy, 2014](http://www.japarliament.gov.jm/attachments/article/1286/1286_2014%20Ministry%20Paper%2063.pdf) addressed crime and violence to achieve sustainable safety and security in Jamaica towards the achievement of- Goal #2 of Vision 2030 - *The Jamaican Society is secure, cohesive and just*. In 2015, the strategic priorities for reducing crime included an organizational review of the Jamaica Constabulary Force (JCF) and the establishment of the Counter Terrorism and Organized Crime Branch, for issues such as gang suppression.[[42]](#footnote-42) Key initiatives were also introduced to combat Trafficking in Persons (TIP), with development of a TIP database, resulting in Jamaica recording its first conviction for human trafficking in 2015.[[43]](#footnote-43)

**Violence against children -** Even though violence against children continues to be a problem,Government is committed to promoting and protecting the rights of children and is in full support of the Global Partnership to End Violence Against Children Initiative. The Partnership brings together governments, foundations, the UN, civil society, academia, the private sector and young people in driving action for the achievement of the new global target to end abuse, exploitation, trafficking and all forms of violence and torture against children.

**Violence against women -**  The UN Human Rights Committee in November 2016 expressed concern that ‘legislation provides women and girls with only limited protection against violence, including domestic violence’. Some of the challenges that exist are: limited work has been conducted with women 25 years and under who have experienced gender-based violence (GBV); shelters are non-existent; and limited availability of psychological and psychosocial expertise to support victims.

The following are some actions taken by Jamaica:

* The adoption of legislative measures aimed at eliminating discrimination against women, including the Domestic Violence (Amendment) Act.
* A Joint Select Committee of Parliament is currently reviewing the Sexual Offences Act 2009.
* The Draft National Strategic Plan of Action to Eliminate Gender-based Violence in Jamaica has been developed as a guiding tool, however, the draft is two years old..

**Violence against the Lesbian, Gay, Bisexual and Transgender (LGBT) community** - Included in the groups most vulnerable to violence and crime is lesbian, gay, bisexual and transgender (LGBT) community who are at risk of, and have experienced victimization and violence as a result of their sexual orientation, gender identity, and/or gender expression.[[44]](#footnote-44) Over the years, the socio-cultural and legal environments have contributed to the prevalence of discrimination and acts of violence against LGBT Jamaicans. Between 2009 and 2012, a total of 231 reports were made to J-FLAG (a human rights organization advocating for a Jamaican society where the human rights of lesbian, gay, bisexual and transgender (LGBT) persons are respected).[[45]](#footnote-45) Efforts such as the introduction of the Diversity Policy and the hosting of a number of human rights-related capacity building and sensitization workshops have been made by the Government, but more still needs to done.

**Road Traffic Accidents**

Road traffic fatality rates were 12.2 deaths /100,000 in 2014 and 14.0 deaths / 100,000 inhabitants in 2015. In 2014, loss of life due to transport crashes was the fifteenth (15th) main cause of death and approximately 55% of the road fatalities were in the most productive age range 15-44 years.[[46]](#footnote-46) Between 2010 and 2015, 80% of the fatalities each year, were male. The National Road Safety Council of Jamaica (NRSCJ) plays a key role in increasing awareness and effective enforcement towards more responsible road usage.

###### ***Communicable Diseases***

The HIV prevalence in 2014 was 1.8 % with an estimated 29, 690 persons living with the virus. From the start of the epidemic in 1982 to December 2014, a total of 33,193 cases of HIV were reported, with 9,278 known to be deceased. With the introduction of universal access to anti-retroviral therapy in 2004, the AIDS death rate declined by 67% from 25 deaths/100,000 population in 2004 to just over 8 deaths/100,000 population in 2014. The number of reported HIV cases reported in 2014 was 1,295 which is a decline of 17% between 2010 to 2014, with the largest decrease occurring with males in the 20-29 year age group. The number of AIDS cases also declined by 41.9%, for the same period.

In 2014, the HIV prevalence among young adolescent girls and boys aged 10-14 years was equal and estimated to be 0.1%, mainly resulting from mother-to-child transmission4. For adolescent girls and boys aged 15-19 years, the prevalence was 0.4% and 0.5%, respectively. However, among gay and bisexual adolescent boys, the estimated prevalence was 14% and for transgender adolescents 27%4. Factors such as inconsistent condom use, stigma and discrimination, and poverty continue to be the underlying factors driving the HIV epidemic.

Jamaica has scaled-up its HIV programme with the implementation of the UNAIDS 90-90-90 programme and increased access to treatment and care services, which includes decentralized CD4 monitoring[[47]](#footnote-47). However, “loss-to-follow-up” (HIV patients who no longer turn up for care and treatment) has emerged as a challenge.

**Vector-Borne Diseases**

Mosquito-borne diseases have posed a serious threat to Jamaica for the past four decades, with increasing frequency of outbreaks over the last ten years. The main contributory factors are:

* Changes in weather patterns
* Globalization with increased trade and travel between countries
* Limited scientific information on epidemiology of emerging diseases
* Immunologically naive population
* Supportive environment for vector proliferation and disease transmission

Currently, 3 mosquito-borne diseases are endemic in Jamaica: Dengue, Chikungunya, and Zika virus. In 2015, dengue remained endemic with outbreaks occurring in 2007, 2010 and 2012. All four (4) serotypes have circulated in the island. *Aedes aegypti* was the only vector found in Jamaica. There were 1,019 and 105 cases reported for 2014 and 2015 respectively, with 73 and 22 laboratory confirmed cases for the same years[[48]](#footnote-48). The Integrated Management Strategy (IMS) for Dengue Prevention and Control was developed and implemented in 2012. The first confirmed case of Chikungunya (CHIKV) in Jamaica was an imported case in July 2014. At the end of the outbreak in 2015, a total of 5,093 cases of CHIKV were reported of which 1,862 were suspected cases. 24% of hospitalizations were children younger than 1 year old and 31% for children up to 4 years.[[49]](#footnote-49)At the end of 2015, no cases of Zika had been reported. The MOH Zika Preparedness and Response Plan was finalized and has been implemented, and aims to heighten awareness of the population, train health care workers and control the spread of mosquitoes.1

**Influenza**

The National Influenza Centre confirmed 37 influenza cases in 2015, an increase of 13% over 2014. Influenza A/H3N2 was the predominant circulating virus.[[50]](#footnote-50) There was a 34% increase in reports of Severe Acute Respiratory Illnesses (SARI) in 2015 (928 cases) over 2014. The seasonal influenza vaccine was available to the private sector and front-line health care workers in the public sector, with voluntary, limited uptake.

###### **Other Health Concerns**

**Nutrition**

The rates of exclusive breastfeeding for infants under 6 months were 15% and 24%, in 2005 and 2011 respectively. The International Code of Marketing of Breastmilk Substitutes (Code) was not formally monitored, with voluntary adherence through policy restriction of direct marketing. In 2015, the Government’s School Feeding Programme (SFP) continued to provide meals for over 312,000 students, which supplied at least one-third of the child’s daily caloric requirements. This has ensured improved school attendance, alleviated hunger and enhanced learning capacity.

**Maternal and Child Health**

Over the years, Jamaica has made significant progress in achieving a number of the global health targets in areas such as HIV and AIDS, poverty reduction, malnutrition and education. However, the country has faced some challenges as it seeks to reduce maternal and infant mortality. In Jamaica, three-quarters of all maternal deaths are caused by complications during delivery and the immediate post-partum period. In 2014, the MOH in collaboration with the European Union (EU) launched the “Programme to Reduce Maternal and Child Mortality (PROMAC)”, which aims to improve the quality of care for expectant mothers and babies. The MOH also receives support through its ‘Safe Motherhood’ campaign, with technical assistance provided by UNICEF, UNFPA and PAHO.

**Healthy Ageing**

Jamaica continues to undergo a demographic transition as life expectancy increases and fertility rates decline. The country will face the increasing challenges of the impact of NCDs and a growing ageing population. To meet these challenges, the MOH must ensure the primary health approaches include programmes and services that support healthy ageing. This will include implementing financial mechanisms to support preventive health care, training of health care workers on issues related to healthy ageing, facilitating savings for long-term care, and creating linkages between health systems, social services, and community resources. Good health helps ensure independence, security, and continued productivity in the later years.

### **2.3 Health Systems Response in Jamaica**

##### **2.3.1 Overview**

The Ministry of Health (MOH), headed by the Minister, is responsible for delivering quality and accessible health care services to the population as it works towards achieving the vision of *“Healthy people, Healthy environment*”. Despite the socio-economic challenges being faced by the country, the MOH remains committed to improving the health status of the population and the well-being of every citizen. Over the years it has made efforts to implement policies and strategies that protect the health system from external shocks. The MOH supports the principle of universal health - “*No Jamaican should be denied access to any clinic or hospital under the public health system if they cannot afford it.*”[[51]](#footnote-51) While the MOH supports the vision of putting the individual at the centre of care, they also encourage individual responsibility and awareness of the environment to ensure the best possible health outcome.

The MOH Head Office is comprised of 5 Divisions: Technical Services, Policy Planning and Development, Standards and Regulation, Human Resource Management and Corporate Services, and Financial Management and Accounting Services. The health system remains decentralized with service delivery being the responsibility of the 4 Regional Health Authorities (RHAs), as stated in the [National Health Services Act, 1997](http://moj.gov.jm/sites/default/files/laws/National%20Health%20Services%20Act_1.pdf) – North East, Western, Southern and South East.

Health service delivery in the public sector is provided through a network of primary (first level of contact), secondary and tertiary care facilities at a highly subsidised cost. In 2015, there were 318 Primary Care Health Centres, 25 hospitals of which 23 are classified as A, B, C and specialist based on the bed capacity and services offered.[[52]](#footnote-52) A list of these services can be found in Annex XXXX. The other 2 are quasi-public hospitals, one of which is the University Hospital of the West Indies which operates within the private health care sector. In 2015 the total bed complement was 4,865 beds.[[53]](#footnote-53) Supportive services are provided through departments and agencies such as the Registrar General, National Public Health Laboratory and the National Health Fund. In 2015, there were 191,333 patient discharges from public hospitals.

There is also a large private health sector with primary and secondary care facilities and diagnostic services. In 2015, there were 10 private hospitals with approximately 200 beds. Referrals between the public and private sectors and vice versa remain a feature of service delivery.

##### **2.3.2. Health Planning**

The strategic priorities for the MOH are: service delivery, health workforce, information, health financing, and governance. The MOH has initiated a strategic planning process for the development of a 10-year plan. It will involve the review of the governance structure to determine the most efficient approach to manage the delivery of health services across the country.

##### **2.3.3. Health Financing**

Financing health care in Jamaica continues to be a major challenge. With the abolition of user fees in 2008 the demand on the resources in the public health care system increased. It also placed additional demand on the existing human resources. In 2015, the GOJ allocated 3.3% of GDP towards health care and 5.9% if the private sector provisions were included.[[54]](#footnote-54) Approximately 86% of MOH’s budget is allocated to the RHAs for providing health care services.

The Government’s health expenditures are financed mainly through tax revenues. The National Health Fund was established to provide financial support to the national healthcare system, to improve its effectiveness and the health of the population. It provides three categories of benefits and services: individual for the purchase of medication; institutional to public and private entities for health projects; and public information/promotional services. The Fund is managed by a board appointed by the Health Ministry and is funded through three mechanisms:

* Tobacco excise taxes;
* Special consumption taxes (alcohol, petroleum and motor vehicles);
* National Insurance Scheme (mandatory payroll contributions of 0.5% of salary paid by employees and employers as well as by independent workers go to the NHF).[[55]](#footnote-55)

However, despite these efforts Jamaica continues to face rising health care costs and decreasing levels of affordability especially for those most vulnerable.

##### **2.3.4. Human Resources**

In 2015, there was a total of 1,166 doctors, 92 dentists and 3,849 nurses in the public sector. The majority worked in the South-East Region, where approximately 50% of the population resided and where the Specialist Hospitals were located. Migration of health professionals continued, in particular of registered nurses focusing on specialist nurses, with active recruitment taking place in Jamaica for overseas markets.

##### **2.3.5. Health Information Technology and Electronic Health Records**

Since 2010, the MOH has strengthened the National Health Information System using the Health Metrics Network (HMN) Framework and Standards. A multi-sectoral Health Information and Technologies (HIT) Steering Committee directed and coordinated activities, including the [National Health Information System Assessment in 2011](http://moh.gov.jm/wp-content/uploads/2015/07/FinalNHISAssessJAMReport.pdf.) and the development of the [National Health Information System Strengthening and E-Health Strategic Plan 2014-2018](http://moh.gov.jm/wp-content/uploads/2015/07/MOH_NHIS-eHealth_StrategicPlanFINAL.pdf). The Plan’s vision for health information systems is *“An integrated National Health Information System supporting timely and efficient data management to produce quality health information for evidence-based decision making at all levels of the National Health System”.*

The MOH sees E-Health and Information & Communication Technologies as key enablers for achieving and measuring Universal Health Coverage and Universal Access. The [E-Health Pilot Project 2014](http://moh.gov.jm/divisions-agencies/divisions/technical-services-division/health-informatics/) used Open Source Software (OSS), for the basis of a Patient Administration System. The use of web technologies to enhance disease surveillance and communication with citizens included the [Surveillance Self-Reporting Online Survey](http://nhis.mohjm.com/survey/index.php?r=survey/index&sid=462121&lang=en.) and Social Media using [Facebook](http://web.facebook.com/themohgovjm?_rdr), [Twitter](http://twitter.com/themohgovjm) and [Instagram](http://www.instagram.com/themohgovjm/). [[56]](#footnote-56)The Standards and Regulation Division, MOH and the Bureau of Standards, Jamaica established various standards for the use of medical technology.

The MOH is also exploring the use of telemedicine to allow remote diagnosis and consultations as well as the storage of images and files in real time. It is hoped that this will reduce the burden on hospitals, the time that patients have to travel and waiting time in hospitals.[[57]](#footnote-57)

##### IHR (TBC)

### 2.4 Cross-cutting issues

###### (equity – “leaving no one behind”, gender, human rights and sustainable development, environmental health, climate change, food and nutritional security)

##### **2.4.1. Equity, Gender and Human Rights**

The integration of equity, gender and human rights is crucial to address the health disparities that exist within a country. These disparities are caused by the underlying social determinants of health (economic and social conditions under which people live that influence the state of their health) and will require an integrated, people-centred approach to how healthcare is planned and delivered. The MOH is committed to providing client-centred services that are accessible to the population including the vulnerable and the disabled. Equity in health is linked to both access and quality and is therefore critical since it contributes to, and sustains poverty reduction efforts.[[58]](#footnote-58) This means that the most vulnerable populations must be included under universal healthcare coverage to ensure “no one is left behind” in the SDA era. Between 2010 and 2012, in Jamaica a larger proportion of persons reported suffering an illness or injury and more than a half of those who sought care did so at public health facilities. Despite the removal of user fees at public health facilities, one-fifth of those who did not seek care reported that they could not afford it.[[59]](#footnote-59)

The Human Development Index (HDI) for 2014 was 0.719 (in the high human development category) – at 99 out of 188 countries and territories, but below the average of 0.744 for this category and that for countries in Latin America and the Caribbean.[[60]](#footnote-60) The HDI is summary measure for assessing long term progress based on a long and healthy life, access to knowledge and a decent standard of living.

Jamaica’s Gender Inequality Index in 2014 was reported to be 0.430, ranking it at 93 out of 155 countries.[[61]](#footnote-61) The Gender Inequality Index reflects gender-based inequalities in reproductive health, empowerment, and economic activity.[[62]](#footnote-62) It measures the loss in human development due to inequality between female and male achievements. Sustainable development cannot be achieved without improving gender inequality. The Jamaica National Policy for Gender Equality (NPGE) was approved by the Government of Jamaica in 2011. Its vision is “*A society in which women and men have equal access to socially valued goods and are able to contribute to national development”.* The policy, which is also aligned with Vision 2030, is being implemented using a holistic gender mainstreaming strategy that incorporates a human rights approach involving the government, private sector and civil society. This ensures that women and men have equal access to opportunities, resources, and rewards towards promoting sustainable human and national development.[[63]](#footnote-63)

In 2016, the United Nations Theme Group on Human Rights and Gender (UNTG) was established in Jamaica to support the UNCT in implementing human rights based development agenda in the Post-2015 and in strengthening the UN’s system’s role. The PAHO CO is member of this theme group. The overall purpose of the UNTG is to institutionalise human rights, gender equality and principles, and mainstreaming as central part of the UN’s developmental work.[[64]](#footnote-64)

##### (Add statements on **Human Rights** in Jamaica).

##### **2.4.2. Environmental Health**

The Water Resources Authority (WRA) manages, protects and controls the allocation and use of Jamaica’s surface and underground water resources. In 2012, 70% of households had piped water in their yards or dwellings, 12.4% utilized rainwater harnessed in tanks and 2.5% used rivers/springs as their source of drinking water. Piped/tap water was the most prevalent source for all regions, with wide variations between urban (94.2%) and rural areas (49.1%).[[65]](#footnote-65) In 2015, the preparation of the Rural Water Supply Development Strategy was advanced. While the El Niño effect reduced the number and severity of weather systems it created serious drought conditions for the island between 2011 and 2015. In 2015 the rainfall was less than the 30-year mean and drought conditions existed for 6 months.

In 2012:

* 99.8% of households had access to improved sanitation, i.e. water closets (73.8%) or pit latrines (26%).
* 63.4% of households used a garbage collection service and 31.9% used burning.

The bauxite companies and power generation companies in 2015 generated hazardous waste totalling 1.8 mega litres of oily sludge (waste hydrocarbon oil/emulsion water). The regulation of activities, apparatuses and facilities involving ionizing radiation and nuclear technology is included in [**The Nuclear Safety and Radiation Protection Act, 2015**](http://www.japarliament.gov.jm/attachments/339_The%20Nuclear%20Safety%20and%20Radiation%20Protection%20bill,%202015.pdf) .

###### **Climate Change and Disaster Preparedness**

Jamaica remains vulnerable to natural and human-induced hazards, such as hurricanes, earthquakes, floods, drought and fires, and their related impact on the social and economic fabric of society. This vulnerability is one of the greatest challenges to the achievement of sustainable development. This is compounded by social issues such as poverty, the location of human settlements in high-risk areas, environmental degradation and instances of poorly constructed infrastructure and housing. The island’s coral reefs, highland forests and mangroves are also vulnerable to climate change.

Jamaica became a party to the United Nations Convention on Biodiversity in 1995. In 2015, habitat loss, climate change, resource over-exploitation, “Invasive Alien Species” and general pollution were identified as the main threats to biodiversity. Other changes that have been made to existing items of legislation include: the [Natural Resources Conservation (Wastewater and Sludge) Regulations, 2013](http://www.nepa.gov.jm/regulations/WasteWater-and-Sludge/Wastwater-and-sludge.pdf) and the [Fishing Industry (Special Fishery Conservation Area) Regulations, 2012](http://moa.gov.jm/Fisheries/legislation_The%20_Fishing_Industry_Special_Fishery_Conservation_Area.php). [[66]](#footnote-66)

###### **Food and Nutritional Security**

A number of policies were introduced or updated to ensure food and nutrition security and to streamline the work of all stakeholders. The “Baby Friendly Hospital Initiative” was implemented in 1993 and 10 hospitals accredited between 1996 and 2001. In 2015, one hospital was re-accredited with plans for at least 4 hospitals per year to be accredited/re-accredited.

The [Food and Nutrition Security Policy, 2013](http://www.japarliament.gov.jm/attachments/article/898/898_Ministry%20Paper%2040-2013%20(The%20Food%20and%20Nutrition%20Security%20Policy).pdf) focused on food availability, access and utilization and stability of food supply. The [National Food Safety Policy, 2013](http://www.moa.gov.jm/AboutUs/departments/National_Food_Safety_Policy.pdf) established a single food safety system to address the relevant areas from “farm to fork”.

##### **2.4.3. Leading Health Challenges**

The main challenges in health are summarized below:

1. Addressing emerging and re-emerging diseases especially those that are mosquito-borne.
2. Reducing the prevalence of NCDs and premature mortality.
3. Promoting healthy lifestyle choices that can improve the quality of life for Jamaicans.
4. Continued strengthening of primary health care approaches that also include programmes and services that promote healthy ageing.
5. Strengthening systems for the diagnosis, treatment and care of noncommunicable diseases.
6. Developing and implementing equitable and sustainable solutions to for financing the health sector in the face of rising health care costs.
7. Recruiting and retaining skill health professionals and reforming the health work-force.
8. Developing effective partnerships that can address cross cutting issues such as violence including gender- based violence, the impact of climate change and environmental health that impact the health care response.
9. Continued strengthening of accountability with a focus on strong public health leadership

### 2.**5 Partnership and Development Cooperation**

##### **2.5.1 Development Environment**

The Planning Institute of Jamaica (PIOJ) coordinates and manages external cooperation agreements and programmes for the Government of Jamaica. Official Development Assistance (ODA) plays a critical role in supporting the achievement of the goals and national outcomes outlined in Vision 2030. In the Caribbean PAHO works closely with many regional organisations in particular:

* [Caribbean Community (CARICOM)](http://www.caricom.org/) which is comprised of twenty (20) countries – fifteen (15) Member States and five (5) Associate States stretching from the Bahamas in the north to Suriname and Guyana in South America, and Belize in Central America. Through the Council for Human and Social Development (COHSOD), CARICOM promotes the improvement of health, education and living and working conditions for the Caribbean Community. Belize has been a full participating since 1974.
* [Caribbean Public Health Agency (CARPHA),](http://carpha.org/)  a new single regional public health agency for the Caribbean which began operations in January 2013. It was legally established in July 2011 by an Inter-Governmental Agreement signed by Caribbean Community Member States.

Jamaica is also a member of other key regional and global organizations such as the Commonwealth of Nations and the Inter-American System through the Organization of American States (OAS). Annex XXX lists the other organizations and development partners that are implementing programmes, projects or initiatives that support the strengthening of the health sector.

##### **2.5.2 Collaboration with the United Nations System at Country-level**

In 2016, the UN national approach was changed to one common [UN Multi-Country Sustainable Development Framework (UN MSDF) for the Caribbean](http://www.unicef.org/about/execboard/files/UNDAF-MSDF-Caribbean.pdf) for the period 2017-2021.[[67]](#footnote-67) The goal of the UN MSDF is to provide the tools, partnerships, and resources needed to achieve national and sub-regional development priorities, in an inclusive and equitable manner, as reflected in the SDGs and the principle of “leave no one behind”. The UN MSDF also contributes to the fulfilment of the SIDS Accelerated Modalities of Action (SAMOA) Pathway and the CARICOM Strategic Plan 2015-2019. Eighteen (18) English- and Dutch-speaking Caribbean countries and Overseas Territories are covered under this MSDF.[[68]](#footnote-68) (See Annex 1.)

This PAHO CCS for Jamaica is aligned to Caribbean UN MSDF and the CO is also involved with the operationalization of the UN MSDF through the implementation of a Country Implementation Plan (CIP)[[69]](#footnote-69) developed by the United Nations Country Team (UNCT). The members of UNCT Jamaica include the United Nations Development Programme (UNDP), United Nations Educational, Scientific And Cultural Organization (UNESCO), United Nations Environment Programme (UNEP), United Nations Population Fund (UNFPA), United Nations Children’s Fund (UNICEF), UNAIDS (Joint United Nations Programme on HIV/AIDS), United Nations Office for Project Services (UNOPS), Food and Agricultural Organization (FAO), and the International Organization for Migration (IOM). The other non-resident agencies that also implement activities in Jamaica are: the United Nations Entity for Gender Equality and the Empowerment of Women (UN WOMEN) and the Economic Commission for Latin America and the Caribbean (ECLAC).

### 2.6 Review of PAHO/WHO’s cooperation over the past CCS cycle

##### **2.6.1 Overall role and responsibilities of PAHO/WHO in Jamaica**

PAHO is the specialized health agency of the Inter-American System and also serves as Regional Office for the Americas of the World Health Organization (WHO), the specialized health agency of the United Nations. It is committed to improving and protecting people’s health ensuring that they have access to quality health care without falling into poverty.

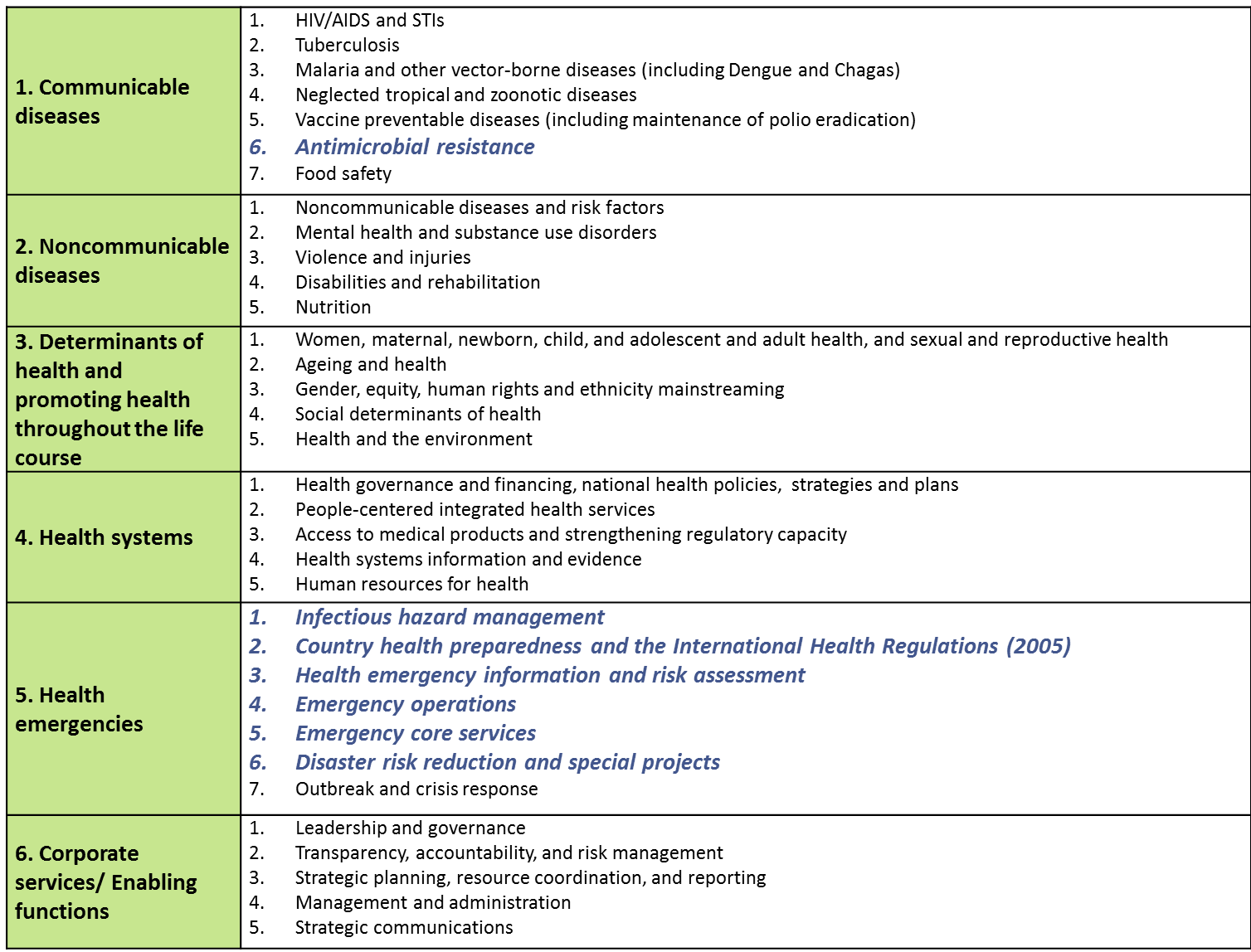
The Pan American Health Organization/World Health Organization (PAHO/WHO) Jamaica Country Office (CO) was opened in 1954 under the administration of the office in Venezuela. In 1962, with Jamaica’s independence the office was re-organised and the programme of technical cooperation expanded to include the Bahamas, Belize, Bermuda, Cayman Islands, and Turks and Caicos Islands. By the early eighties the Bahamas Office was established with responsibility for The Turks and Caicos Islands. This was followed by Belize establishing its own office. The current CO provides technical cooperation to Jamaica, and 2 United Kingdom Overseas Territories, Bermuda and the Cayman Islands. The CO works with its national counterparts in Jamaica and the territories it covers.

The PAHO/WHO Jamaica Office works closely with all levels of PAHO/WHO at the subregional, regional and global levels to fight communicable and noncommunicable diseases and their causes, to strengthen health systems, to respond to emergencies and disasters, and to address the social determinants of health. Two (2) De-centralised Regional Advisers who report to the Caribbean Sub-regional Office in Barbados are based in the Jamaica CO providing technical cooperation to the Caribbean in Immunization and Nutrition. The CO is headed by the PAHO/WHO Representative who works with a staff complement of XXXXX with 3 international professionals (including the PWR) and 1 International Consultant.

The PAHO CO is located on the Mona Campus of the University of the West Indies and over the years it has developed a close working relationship with the various departments of the University. Over the years, the CO has piloted a number of PAHO/WHO initiatives for the Caribbean. The most recent ones include: To be completed

##### **2.6.2. The PAHO Strategic Plan**

The activities and interventions implemented by the PAHO/WHO Belize Office are closely aligned to the PAHO Strategic Plan 2014-2019, *“Championing Health: Sustainable Development and Equity”*. This Plan builds upon important past achievements, the strengths of its Member States, and the competence of the Pan American Sanitary Bureau (PASB). It sets out the Organization’s strategic direction, based on the collective priorities of its Member States and country focus, and specifies the results to be achieved during the period 2014-2019. Its vision focuses on healthy living and well-being and reaffirms health as a key element of sustainable development. It has 6 categories and 34 program areas, the new program areas are in italics.

**Table X. PAHO Strategic Plan - Categories and Program Areas**

Source: PAHO – Planning Budget 2018/2019 presentation

##### **2.6.3. Results of the Stakeholder Survey**

## 3. The Strategic Agenda

3.1 Strategic Priorities (SP) – maximum of 5

*(Each strategic priority should contribute to achieving at least one NHPSP priority as well as the health and health-related targets. The achievement of each SP is the joint responsibility of the Government of Jamaica (?????)and PAHO/WHO.)*

### 3.2 Focus Areas (FAs) related to each SP

*(The focus areas are the “what” under each strategic priority to which PAHO collaboration will contribute. They are designed using a SMART format (specific, measurable, achievable, realistic and time-bound)*

### 3.3 Table Aligning SPs and FAs to NHPSP, the PAHO Strategic Plan Outcomes, CCH IV, the SDG Targets and UNDAF Outcomes.

## 4. Implementation of the CCS

#### 4.1 Coordination and management

#### 4.2 Core Resources needed for implementation (human, financial, communication technology etc.)

*(Does the country office have the core capacity (in terms of infrastructure, human and financial resources) and other resources needed to implement the Strategic Agenda? If not, what are the implications for the Secretariat to fill the gaps in terms of priority-setting, programming and accountability? What shifts will the country office make in its programmatic focus and what broad changes will be made in the skills mix of the country team?)*

## 5. Monitoring and Evaluation

#### 5.1 Mid-term evaluation

#### 5.2 Final evaluation

### References

### Annex 1. SDGs and the 2017-2021 UN MSDF for the Caribbean

At the United Nations Sustainable Development Summit on 25 September 2015, world leaders adopted the 2030 Agenda for Sustainable Development, which includes a set of seventeen (17) Sustainable Development Goals (SDGs) (Figure 3.). Each goal is important in itself and they are all interconnected. The SDGs recognize that eradicating poverty and inequality, creating inclusive economic growth and preserving the planet are linked and have as an overarching theme: “Leaving no one behind”. They promote a comprehensive, integrated approach to sustainable development.[[70]](#footnote-70)



#### Figure 2. The Sustainable Development Goals

*Source:* [*https://sustainabledevelopment.un.org/sdgs. Accessed July 2016*](https://sustainabledevelopment.un.org/sdgs.%20Accessed%20July%202016)

The SDGs, and the broader sustainability agenda, go much further than the MDGs, addressing the root causes of poverty. They recognise that eradicating poverty and inequality, creating inclusive economic growth and preserving the planet are linked, and has as it overarching theme: **“Leaving no one behind”**. It promotes a comprehensive, integrated approach to sustainable development. The Goals will stimulate action over the next fifteen (15) years in five (5) areas of critical importance: ***People, Planet, Prosperity, Peace and Partnership****.*

Only one SDG, SDG 3, is dedicated entirely to health *“To ensure healthy lives and promote well-being for all at all ages”*. It includes nine (9) targets which cover major health priorities and four (4) “means of implementation” targets. It addresses a wide range of health issues from road traffic injuries and tobacco control, to the health workforce and noncommunicable diseases (NCDs) — the most conspicuous health concern that was omitted from the MDGs. However, Health also benefits from the achievement of the other SDGs.

##### UN MSDF for the Caribbean

The goal of the UN MSDF is to provide the tools, partnerships, and resources needed to achieve national and sub-regional development priorities, in an inclusive and equitable manner, as reflected in the SDGs and the principle of **“leave no one behind”.** The UN MSDF also contributes to the fulfilment of the SIDS Accelerated Modalities of Action (SAMOA) Pathway and the CARICOM Strategic Plan 2015-2019. Eighteen (18) English- and Dutch-speaking Caribbean countries and Overseas Territories are covered under this UN MSDF.

**Caribbean UN MSDF 2017-2021 Priority Areas:**

**Priority 1** **- an inclusive, equitable, and prosperous Caribbean**: *With an emphasis on the most vulnerable groups, promote social and economic inclusion and equity while improving social protection and [the] access to decent employment within a sustainable economy.*

**Priority 2** **- a healthy Caribbean**: *Improve health and well-being by addressing the ability of the state to provide services, increasing access to healthy nutrition, a healthy environment and knowledge as preventive measures. Sustainable health financing and direct action to address NCDs, SRH and HIV/AIDS and related stigma are also necessary for better health outcomes.*

**Priority 3 - a cohesive, safe, and just Caribbean:** *Support the creation of conditions for a safe and just Caribbean while addressing the root causes that promote and perpetuate violence and insecurity.*

**Priority 4** - **a sustainable and resilient Caribbean*:*** *Support coherent efforts to strengthen the resilience of the Caribbean and its peoples by mitigating the effects of climate change, disasters and environmental degradation on sustainable development, livelihoods,* *and the economies.*

### Annex 2. Table Vision 2030 Jamaica – National Goals and Outcomes

|  |  |
| --- | --- |
| **The National Goals** | **The National Outcomes** |
| **Jamaicans are empowered to**  **achieve their fullest potential** | 1. **A Healthy and Stable Population** 2. **World-Class Education and Training** 3. **Effective Social Protection** 4. **Authentic and Transformational Culture** |
| **The Jamaican society is secure,**  **cohesive and just** | 1. **Security and Safety** 2. **Effective Governance** |
| **Jamaica’s economy is prosperous** | 1. **A Stable Macroeconomy** 2. **An Enabling Business Environment** 3. **Strong Economic Infrastructure** 4. **Energy Security and Efficiency** 5. **A Technology-Enabled Society** |
| **Jamaica has a healthy natural**  **environment** | 1. **Internationally Competitive Industry Structures** 2. **Sustainable Management and Use of Environmental**   **and Natural Resources**   1. **Hazard Risk Reduction and Adaptation to Climate**   **Change**   1. **Sustainable Urban and Rural Development** |

### Annex 3. MOH Strategic Objectives, Services and Initiatives

**Strategic Objectives**

The Ministry of Health’s strategic objectives are as follows:

1. Provide the Jamaican population with health care service that is accessible and of the highest attainable standard
2. Maintain and develop a qualified and professional workforce for the delivery of health and allied services
3. Improve the quality of health information systems for planning and management of the health services
4. Develop and monitor the implementation of viable health financing options
5. Strengthen governance mechanisms in the areas of compliance, accountability, policy, legislative, and regulatory systems

##### **Services**

1. Prevention and control of non-communicable diseases

2. Prevention and control of communicable diseases (vector-borne diseases)

3. Maternal, Adolescent and Child Health.

4. Information Systems for Health

5. Human Resource

6. Health Financing

##### **New Initiatives**

* Upgrading of the Spanish Town Hospital from a Type B to a Type A facility
* Cancer Care System of Excellence
* Construction of the Ministry’s Corporate Headquarters
* Child and Adolescent Hospital in Western Jamaica
* The Adopt-a-Clinic programme
* Accident and Emergency (A&E) pilot to reduce waiting times
* Expansion of the Pharmaceutical Services
* Development and implementation of a Volunteer’s Policy
* Provision of Dental Sealant and Flouride Varnish programme for the primary school
* Physical Activity Campaign (Jamaica Moves)
* Development of a National Health Insurance Plan
* Public/private partnerships in health to support services and infrastructural

development.

Annex 4 - Key Stakeholder Analysis **(To be Completed with feedback from the Working Group)**

| **Name of Agency** | **Role fulfilled by Subregional Initiatives/ Development Partners/ International Funding Institutions** | **Health-related SDG target** | **Major Programmatic area of support within country** |
| --- | --- | --- | --- |
|  |
| **Caribbean Community (CARICOM) /COHSOD)[[71]](#footnote-71)** | **Subregional Cooperation** - Caribbean Cooperation in Health IV which is the framework that guides public health in the Caribbean  Community. | All the health targets under SDG 3 (3.1-3.9) | Guides the implementation of public health in the Caribbean at the national level is aligned with the priorities and needs of the MOH |
|  | **Subregional Cooperation** - Elimination of mother-to-child  transmission of HIV (EMTCT) | 3.2 End preventable deaths of newborn and children under 5 years of age  3.3 End epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases, and combat hepatitis, water-borne diseases and other communicable diseases |  |
|  | **Subregional Cooperation -** Findings ofEvaluation of Port of Spain Declaration presented at COSHOD | 3.a Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate | Guides the prevention and control of NCDs and the related risk factors in the Caribbean and is aligned with the national NCD Plan. |
|  | **Subregional Cooperation -** Elimination of Measles and the Introduction of Inactivated  Poliovirus Vaccine | 3.2 End preventable deaths of newborns and children under 5 years of age  3.b Support research and development of vaccines, medicines for communicable and noncommunicable diseases that primarily affect developing countries, and provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health |  |
|  | **Subregional Cooperation -** International Health Regulations | 3.d Strengthen capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks | Guides the implementation of IHR in the Caribbean at the national level is aligned with the IHR priorities of the MOH |
| **CARICOM Head of Government 27th Intersessional**  **Meeting** | **Policy dialogue -** Declaration on  a course of action to address the Zika virus | 3.3 End epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases |  |
| **CARICOM/ CARPHA** | **Subregional Cooperation -** Regional Health Information System  Task Force and its strategic remit | 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all |  |
|  | **Subregional Cooperation -** Health systems strengthening | 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all |  |
| **Development Partners** |
| **United States Agency for International Development** | **Technical Assistance**  USAID’s Caribbean Clean Energy Program (CARCEP) | 13.b Promote mechanisms for raising capacity for effective climate change-related planning and management in least developed countries and small island developing States, including focusing on women, youth and local and marginalized communities | To accelerate clean energy development in the region, with special focus on Jamaica and the Eastern Caribbean. |
|  | **Climate Economic Analysis for Development, Investment, and Resilience (CEADIR)** | 13.b Promote mechanisms for raising capacity for effective climate change-related planning and  management in least developed countries and small island developing States, including focusing on women, youth and local and marginalized communities | To help governments, the private sector, and civil society make the business and economic case for investing in climate change mitigation and adaptation. |
|  | **Caribbean Marine Biodiversity Program** | 13.3 Improve education, awareness-raising and human and institutional capacity on climate change mitigation, adaptation, impact reduction and early warning | To reduce the threats to marine-coastal biodiversity in priority areas in the Caribbean in order to achieve sustained biodiversity conservation, maintain critical ecosystem services, and realize tangible improvements in human well-being for communities adjacent to marine managed areas |
|  | **Jamaica Rural Economy and Ecosystems Adapting to Climate Change II (Ja REEACH II)** | 13.1 Strengthen resilience and adaptive capacity to climate-related hazards and natural disasters in all countries | To promote the protection of rural lives, livelihoods and ecosystems through interventions that increased and strengthened climate change resilience. |
|  | **U.S. President's Emergency Plan for AIDS Relief (PEPFAR)** | 3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases. | To help save the lives of those suffering from HIV/AIDS around the world. |
|  | **Fi Wi Jamaica** | 10.3 Ensure equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action in this regard  5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation | To building public demand for the promotion of social change that will respect and protect human rights and dignity regardless of gender and sexual orientation; raise the quality of dialogue regarding inclusivity, diversity equality, and fairness for the LGBTI community; and support key stakeholders in delivering services to women and girls who are victims or potential victims of gender based violence. |
| **European Union (EU) –** | **Development Cooperation** -  PROMAC –Programme for the Reduction of Maternal and Child Mortality | 3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births  3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births | To improve the services available to maternal emergencies  To reduce neonatal deaths and improve neonatal health by improving both capacity and facility available for resuscitation of the new born. |
| **European Union /UNEP** | **Development Cooperation – Climate Change Adaptation and Disaster Reduction Project** | 13.1 Strengthen resilience and adaptive capacity to climate-related hazards and natural disasters in all countries | Project seeks to reduce risks and assist with adaptation to climate change |
| **Japan International Cooperation Agency (JICA)** | **Technical Cooperation -** |  |  |
| **Organization of American States (OAS)** | **Technical Cooperation** |  |  |
| **International Development Bank (IDB)** | **Development Funding -**  Programme of Advancement through Health and Education (PATH) | 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all | To support Jamaica’s Social Protection Strategy that assists the most vulnerable and needy in the society, particularly children and pregnant and lactating mothers. |
|  | **Strengthening of Health Systems Project** |  | To assist the MOH in defining policies,  developing a ten year strategic plan along with implementations plans to inform projects/ programmes intended to protect and enhance health gains of the population |
| **Embassy Republic of Cuba** | **Technical Cooperation** |  | Agreement between the Ministry of Public Health of the Republic of Cuba and the Ministry of Health  Agreement on Cooperation between Cuba and Jamaica for the functioning of an Ophthalmology Centre. |
| **Republic of China** | **Technical Assistance** |  | To build of the Western Children’s Hospital in Montego Bay, St James. |
|  |
| **United Nations Country Team (UNCT) [[72]](#footnote-72)** | Technical Assistance |  | Four main areas (a) access to equitable social protection systems and basic services; (b) democratic governance, citizen’s security and safety; (c) resilience to climate change and natural disasters and universal access to clean energy; and (d) natural resource management.[[73]](#footnote-73) |

##### **National Organisations** (to be completed based on feedback from the WG)

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| --- | --- | --- |
|  | **Organisations** | **Major Programmatic area of support within country** |
|  | Planning Institute of Jamaica | Initiating and coordinating the development of policies, plan and programmes for the economic, financial, social, cultural and physical development of Jamaica.  Advising the Government on major issues relating to economic, environmental and social policy. |
|  | Jamaica National Family Planning Board |  |
|  | Fathers in Action |  |
|  | Food for the Poor |  |
|  | Jamaica Cancer Society |  |
|  | Jamaica AIDS Support |  |
|  | Jamaica Bureau of Standards |  |
|  | Jamaica Council for Persons with Disabilities |  |
|  | Jamaicans for Justice |  |
|  | Media Association of Jamaica |  |
|  | Medical Association of Jamaica |  |
|  | National AIDS Committee Jamaica |  |

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