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LEGAL AND REGULATORY ASSESSMENT FOR GOVERNMENT FUNDING OF CIVIL SOCIETY ORGANIZATIONS TO DELIVER HIV SERVICES IN JAMAICA

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HP+ HEALTH POLICY PLUS

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Abbreviations

AIDS	acquired immune deficiency syndrome
ARV	antiretroviral
CHASE	Culture, Health, Arts, Sports and Early Childhood Education [Fund]
CSO	civil society organization
DCFS	Department of Co-operatives and Friendly Societies
GDP	gross domestic product
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	human immunodeficiency virus
HP+	Health Policy Plus
NHIP	National Health Insurance Plan for Jamaica
MOF&PS	Ministry of Finance and Public Service
MOH&W	Ministry of Health and Wellness
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PIMS	Public Investment Management System
PIOJ	Planning Institute of Jamaica
USAID	U.S. Agency for International Development
SRH	sexual and reproductive health
STI	sexually transmitted infection
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS

Executive Summary

As external funding for HIV programs in Jamaica is decreasing, Health Policy Plus is providing technical assistance to government and civil society partners in Jamaica to develop sustainable policies, guidelines, and practices for the national HIV response. In the context of the implementation of the new Global Sustainability, Transition and Co-financing Policy (2016), the Global Fund to Fight AIDS, Tuberculosis and Malaria developed a social contracting diagnostic tool to better understand the complex barriers to and opportunities for the continuation of evidence-based and cost-effective interventions for key populations implemented by civil society organizations (CSOs) through public financing. The tool defines social contracting as the process by which government resources are used to fund CSOs to provide services that the government has a responsibility to provide in order to ensure the health of its citizenry (AMPG Health, 2017).

The tool is intended to guide countries in assessing whether (1) CSOs are legally permitted to register as legal entities; (2) registered CSOs can receive funds from the government; (3) registered CSOs can use those government funds to contribute to HIV, tuberculosis (TB), and malaria responses, particularly among key populations at risk; and (4) CSOs are substantially involved in planning and implementing HIV, TB, and malaria responses among key populations. The tool is designed to be used primarily in countries where significant changes are predicted for external funding and where external funding has been channeled through CSOs to implement key interventions in the HIV, TB, and/or malaria responses.

An assessment of the legal and regulatory framework for social contracting in Jamaica was conducted during seven weeks in May and June 2019. The findings of this assessment confirm that the framework exists for the Government of Jamaica to contract with CSOs for the provision of services related to HIV. These findings are welcome in light of the State's commitment to ensure that by 2020, at least 30 percent of all service delivery for HIV will be community-led, whereby CSOs will continue their important role in "reaching, testing and retaining people living with HIV and key populations into services" (National Family Planning Board–Sexual and Reproductive Health Agency, 2017, pg. 83). Together, strengthening and ensuring the sustainability of community-led service delivery support efforts toward achieving the UNAIDS "90-90-90" targets, while simultaneously working toward achieving the complementary Sustainable Development Goals and the *Vision 2030 Jamaica National Development Plan* (Planning Institute of Jamaica, 2010). Social contracting is also in line with the general ethos and direction of the Ministry of Health and Wellness (MOH&W), as Strategic Goal 6 of the *Vision for Health 2030—Ten Year Strategic Plan* (MOH&W, 2019c) expressly considers a partnership with private entities to outsource nonclinical support services and select clinical support services. The climate for social contracting is ripe, as evidenced by the recent pronouncements of the Minister of Health and Wellness on the decision of the ministry to outsource some health services, such as surgeries and diagnostic tests, in an effort to reduce waiting time in the public health system (Jamaica Information Service, 2019). In addition, the findings of this assessment on Jamaica's legal and regulatory framework should serve to extinguish any anxiety as to whether social contracting is feasible in Jamaica.

The answers to the core questions of the social contracting diagnostic tool are as follows:

1. **Are CSOs legally permitted to register? Yes.**

   The Constitution of Jamaica (1962) section 13(3)(e) guarantees the right to freedom of peaceful assembly and association. The protection of this right is such that it applies to all law and binds the legislature, the Executive branch of government, and all public authorities. CSOs can be registered as a legal entity under the Companies Act and the Friendly Societies Act, or as a charitable organization under the Charities Act.

2. **Are CSOs legally permitted to receive funds from the government or to contract with the government? Yes.**

   The framework in place allows this. The Financial Administration and Audit Act (1959) governs the control and management of the country's public finance. It sets out the laws specific to the consolidated fund; contingency funds and other funds, loans, and advances; government accounts; audits; government property; public bodies; and the fiscal responsibility framework. The Public Procurement Act completes this framework by governing the public procurement of goods, services, and works. There is an ad hoc practice of providing subventions to select CSOs, with the broad authority for providing such subventions set out generally in the Financial Administration and Audit Act. Within the context of this report, the term "subvention" is understood to mean a discretionary grant of money from the government.

3. **Can CSOs be contracted by the government to provide HIV-related services, particularly among key populations? Yes.**

   CSOs are guided by restrictions governing the provision of health services that require licenses and professional qualifications, which apply to all CSOs regardless of whether they are working on HIV. There are no specific restrictions to CSOs being contracted from the government budget, nor are there any specific restrictions to CSOs that are being funded by the government budget or that are contracted by the government to provide HIV services to gay, bisexual, and other men who have sex with men; people who use drugs; transgender people; sex workers; incarcerated people; adolescent girls; and people living with HIV.

4. **Is civil society sufficiently and sustainably involved in planning, implementing, and budgeting for HIV responses? No.**

   CSOs provide more than 20 percent of all HIV-related services in Jamaica. They participate in the design and implementation of the HIV response generally via the *National Integrated Strategic Plan for Sexual and Reproductive Health and HIV 2014–2019,* and more specifically via the implementation agreement between the MOH&W and the subrecipients of funding from the Global Fund. However, the influence and inclusion of CSOs have not extended to the budgeting and domestic financing of the response. While CSOs contribute to the proposals and negotiations for grants and funding from international donors, they are not involved in any part of the budgeting processes for the Government of Jamaica or the MOH&W, even beyond budgeting for HIV services.

1. Introduction

1.1 Background to Social Contracting Analysis

As external funding for HIV programs in Jamaica is decreasing, the Health Policy Plus (HP+) project, funded by the U.S. Agency for International Development (USAID), is providing technical assistance to government and civil society partners in Jamaica to develop sustainable policies, guidelines, and practices for the national HIV response. In the context of the implementation of the new Global Sustainability, Transition and Co-financing Policy (2016), the Global Fund to Fight AIDS, Tuberculosis and Malaria developed a social contracting diagnostic tool to better understand the complex barriers to and opportunities for the continuation of evidence-based and cost-effective interventions for key populations implemented by civil society organizations (CSOs) through public financing. The tool defines social contracting as the process by which government resources are used to fund CSOs to provide services that the government has a responsibility to provide in order to assure the health of its citizenry (AMPG Health, 2017).

The tool is intended to guide countries in assessing whether (1) CSOs are legally permitted to register as legal entities; (2) registered CSOs can receive funds from the government; (3) registered CSOs can use those government funds to contribute to HIV, tuberculosis (TB), and malaria responses, particularly among key populations at risk; and (4) CSOs are substantially involved in planning and implementing HIV, TB, and malaria responses among key populations. The tool is designed to be used primarily in countries where significant changes are predicted for external funding and where external funding has been channeled through CSOs to implement key interventions in the HIV, TB, and/or malaria responses.

The tool assists in answering the following questions:

- Is it possible for the government to directly contract with or provide grants to CSOs within the existing legal and policy framework in the country?
- What are the structural and regulatory barriers that hinder the government's ability to directly fund CSOs for the provision of HIV prevention, care, and treatment services?
- What are the specific CSO strengths/opportunities for social contracting?
- What mechanism would be the most useful?

It is increasingly being recognized that achieving a successful transition includes ensuring that (1) the role for CSOs is clearly defined, including targets and budgets; (2) a legal framework is in place that facilitates CSOs' work on HIV; (3) a mechanism exists to provide both governments and CSOs with the tools needed so the work can be done effectively and can be reported on both programmatically and financially to all parties' satisfaction; and (4) a funded mechanism exists that facilitates community monitoring of the HIV response (AMPG Health, 2017).

The findings of this assessment of Jamaica's legal, regulatory, and policy framework confirm that the framework exists for the Government of Jamaica to contract with CSOs for the provision of services related to HIV. This should serve to extinguish any anxiety as to whether social contracting is feasible in Jamaica.

1.2 Methodology

The assessment of Jamaica's legal and regulatory framework was conducted during seven weeks in May and June 2019. The methodology for this assessment and for implementing the social contracting diagnostic tool consisted of the following:

Step 1: Prior discussion

There was prior discussion among government, donor partners, and CSO stakeholders regarding social contracting and initiation of work on social contracting analysis.

Step 2: Adaptation of the tool to the country context

Prior to commencement of the social contracting analysis, the tool was adapted by:

- Identifying key populations and stakeholders in Jamaica and adapting the questions in the tool to ensure that it was tailored to the local context and responded to the needs, concerns, and priorities of the key populations and stakeholders.
- Developing sector-specific questionnaires to facilitate robust discussions with key stakeholders. Specific questionnaires were developed for the Jamaica Country Coordinating Mechanism; Ministry of Health and Wellness (MOH&W), including for the Permanent Secretary to the MOH&W and for the National HIV/STI/TB Unit, Health Promotion and Protection Branch in the MOH&W; Ministry of Finance and Public Service (MOF&PS); Department of Co-operatives and Friendly Societies; Ministry of Education, Youth and Information; Office of the Public Defender; CSOs in receipt of Global Fund funding that are working with people living with HIV and key populations; the Caribbean Vulnerable Communities Coalition; AIDS HealthCare Foundation; Heart Foundation of Jamaica; Stand Up Jamaica; and the Joint United Nations Programme on HIV/AIDS (UNAIDS).

Step 3: Desk review

To conduct the desk review, the consultant first developed an outline of the legal and regulatory issues for social contracting that were specifically related to the social contracting diagnostic tool. This allowed for clear identification of the objectives under each section of the tool and, in turn, facilitated gathering the relevant sources of laws, policies, strategies, and plans for review. The desk review included primary documentary sources such as legislation, regulations, policies, strategies, and plans, as well as national reports and other secondary quantitative data.

The desk review was completed to determine the following:

- The existing relationships between the government and CSOs, in general, and the health sector, in particular
- The current level of Global Fund funding to the State and the existing grants and allocations to CSOs
- How CSOs can register as legal entities and work with key populations, and whether any legal restrictions or barriers exist

- The health services CSOs may provide, in accordance with applicable laws and the licensing requirements, if any
- The process for obtaining the appropriate licenses
- Whether there are restrictions on hiring practices within CSOs
- Laws, regulations, and guidelines that govern government procurement of goods and services
- Whether and how CSOs can be funded from the national budget and whether there are any restrictions on funding to CSOs that provide services related to HIV or work with key populations
- How CSOs are envisioned or referenced in national plans for HIV
- How CSOs are included in the government planning and budget development processes
- The procurement practices of government, as well as rules and procedures where the government contracts with CSOs or where it funds CSOs from the national budget
- Mechanisms in place to allow for transparency and accountability and to safeguard against corruption

More than 37 pieces of legislation were reviewed together with relevant policy documents and reports (see Annex A: Details of Desk Review), including the *Vision for Health 2030—Ten Year Strategic Plan* (MOH&W, 2019c), *National Integrated Strategic Plan for Sexual and Reproductive Health and HIV 2014–2019, Revised National HIV Policy 2017,* and the *Strategic Business Plan, 2015–2018* (Ministry of Health [MOH], 2014).

Step 4: Stakeholder interviews

Stakeholder interviews provided further insight into the information obtained via the desk review. Most of the interviews were conducted face-to-face. Key informants included representatives of key government ministries, CSOs that receive funding from the Global Fund and will be directly affected by the removal of this funding source, other CSOs providing non-HIV-related health services, and one key development partner. Interviews were conducted with:

- **Government**: The MOH&W, including the Office of the Permanent Secretary to the MOH&W; the National HIV/STI/TB Unit; Health Promotion and Protection Branch; MOF&PS; Department of Co-operatives and Friendly Societies; Ministry of Education, Youth and Information; Office of the Public Defender; Planning Institute of Jamaica; and the Public Procurement Commission
- **Civil society organizations**: Children First, Hope Worldwide, Jamaica AIDS Support for Life, Transwave, JN+, JCW+, Eve for Life, Larry Chang Foundation, Caribbean Vulnerable Communities Coalition, Stand up Jamaica, and Heart Foundation of Jamaica
- **Other key informants**: Jamaica Country Coordinating Mechanism, AIDS Healthcare Foundation
- **Development partner:** UNAIDS

The consultations were guided by the principle of informed consent (American Bar Association Rule of Law Initiative, 2012), and measures were taken to ensure confidentiality in the use of information collected from people living with HIV and other stakeholders. This included stripping the data of personal identifiers, restricting access to the data to a limited number of individuals working on or overseeing the assessment, and ensuring that the information contained in the interview notes was kept confidential by the consultant.

Step 5: Preparation of draft report

Step 6: Meeting with MOH&W

A meeting was held with the MOH&W to share the key findings of this assessment. This was also intended as an opportunity for the MOH&W to provide feedback on the findings and on the implementation of social contracting in Jamaica.

Step 6: Finalization of report

2. Jamaica Country Context

2.1 Socioeconomic and Demographic Context

Jamaica has a Human Development Index of 0.732, favorably positioning the country at 97 of 189 countries. The total population is approximately 2.9 million, and the life expectancy at birth is 76.1 years (United Nations Development Programme, n.d.). Jamaica is classified as an upper-middle-income economy. It struggles with low growth, high public debt, and exposure to external shocks. The World Bank reports that in 2013, Jamaica launched an ambitious reform program to stabilize the economy, reduce debt, and fuel growth, gaining national and international support. Public debt fell below 100 percent of gross domestic product (GDP) in 2018–2019. The employment rate in October 2018 was 8.7 percent, a reduction of 1.8 percentage points relative to 10.5 percent in October 2017, and almost half the rate at the start of the reform program. The Jamaican economy grew 2.0 percent in the fourth quarter of 2018 compared to the previous year, bolstered by growth in agriculture, manufacturing, construction, mining, and quarrying activities. Inequality in Jamaica is lower than in most countries in the Latin America and Caribbean region, but poverty, at 17.1 percent in 2016, is still significant. Crime and violence levels remain high, emphasizing the need to address the issues of youth unemployment, education, and social cohesion (World Bank, 2019).

The State has acknowledged that the HIV epidemic is also closely tied to poverty and related development issues, including the slow rate of economic growth, high levels of unemployment, low educational attainment, especially among males, and crime and violence. The epidemic threatens national productivity because the majority of cases occur in groups of reproductive and working age (MOH&W, 2015). The MOH&W has further acknowledged that some of these issues, in particular issues relating to poverty and unemployment, contribute to the inequity in some health outcomes. Violence and injuries place a burden on the health system, with violence being the second leading cause of death for people 35–45 years (MOH&W, 2019). The MOH&W has pointed out that Jamaica is experiencing an epidemiological transition, population growth, and demographic changes, as well as increased demand for primary and secondary healthcare services that are challenging the current public health infrastructure. Consequently, there is a need to rehabilitate, upgrade, expand, modernize, and equip the health services infrastructure to be responsive to the changing health needs of the country. Therefore, over the next five years, the MOH&W is considering making appropriate capital investments to facilitate improvements in both the primary care (health centers) and secondary care (hospitals) infrastructure and equipment. These investments will be geared toward improvements in the quality and quantity of healthcare services to be provided, integrated service delivery for the seamless movement of patients between the different levels of care, improved health information systems for better patient management and management of the public healthcare services, and a more customer-focused service (MOH&W, 2019a). This presents an opportunity for CSOs to capitalize on the MOH&W's efforts to improve the quality and quantity of healthcare services.

2.2 Status of the Epidemic

HIV and AIDS cases and deaths in Jamaica have been decreasing steadily over the last 10 years (MOH&W, 2019c). As of 2017, it was estimated that there were 34,000 people living with HIV in Jamaica, but approximately 22 percent of these people were unaware of their status. In 2017,

there were 1,197 newly diagnosed cases, representing a significant decline from the 2,015 cases reported in 2016. People ages 20–29 years accounted for the largest proportion (26 percent) of newly diagnosed cases, followed by those 30–39 years, who accounted for 24 percent of the total reported cases. The AIDS mortality rate declined from 25 deaths/100,000 population in 2004, to just over 10 deaths/100,000 population in 2017. According to the National HIV/STI/TB Unit, this represents a significant decline since the inception of universal access to antiretrovirals (ARVs) in 2004 (MOH&W, 2017).

The National HIV/STI/TB Unit also reports that Jamaica continues to exhibit features of both a generalized and concentrated HIV epidemic. The prevalence in the general population is estimated at 1.8 percent; however, surveys show higher HIV prevalence in at-risk groups. HIV prevalence among female sex workers has decreased from 2.9 percent in 2014 to 2 percent in 2017. As of the end of 2017, the prevalence rates among men who have sex with men and people of transgender experience are estimated to be 32 percent and 52 percent, respectively (MOH, 2017).

According to the latest report from the National HIV/STI/TB Unit, the main factors fueling the HIV epidemic in Jamaica include "history of STIs [sexually transmitted infections], men having sex with men, multiple sex partners, and sex with sex workers" (MOH, 2017, pg. 12). Other factors include "early sexual debut, multiple sexual partners, high levels of transactional sex, gender inequalities, inadequate condom use, and homophobia" (MOH&W, 2015, pg. 14). The HIV epidemic is also closely tied to poverty, crime, and violence (MOH&W, 2015).

2.3 Key Populations and Human Rights

Key populations face a higher HIV risk compared to the general population, have less access to information and services, and often face multiple and overlapping vulnerabilities. These populations include men who have sex with men, female sex workers, persons of transgender experience, homeless drug users, people who are incarcerated, and youth and adolescents. People living with HIV and key populations may experience multiple forms of discrimination. They often experience rights violation in different ways, as their experiences tend to be shaped by the interactions between their different social identities and characteristics (Myrie, 2017).

The human rights issues that arise within the context of HIV and AIDS in Jamaica include stigma and discrimination, privacy and confidentiality, access to and quality of healthcare services, gender-based violence and intimate partner violence, access to information, sexual and reproductive rights, access to legal services, property rights, and protection of the law. Strategic Priority 3 of the *National Integrated Strategic Plan for Sexual and Reproductive Health 2014–2019* is consequently focused on creating an enabling environment and securing human rights. Strategic Priority 3 expressly recognizes that stigma and discrimination toward people living with HIV and their families, men who have sex with men, and sex workers continue to adversely affect testing, uptake of HIV-related services, adherence to antiretroviral therapy, and access to supportive services. Therefore, strategies aim to alleviate the barriers that increase vulnerability to HIV, other STIs, gender-based violence, and unplanned pregnancies. The main outcome associated with Strategic Priority 3 is a strengthened policy and legal framework for sexual and reproductive health and HIV prevention, treatment, and care services. Upon the successful implementation of this strategic plan, the expectations are that:

1. Policy and legislative barriers to sexual and reproductive health information, goods, and services will have been addressed.
2. Human rights and policy monitoring by CSOs is being undertaken.
3. Nondiscriminatory health services are being provided to all, particularly youth, women, and key populations.
4. A comprehensive framework for promoting redress will have been established and is being upheld by duty bearers.
5. The legal and policy environment for effective implementation of adolescent and youth reproductive health programs will have been addressed.
6. The framework for mainstreaming gender and reproductive rights will have been established (MOH&W, 2015).

2.4 Rights Protection in Jamaica

The following laws were reviewed:

- Constitution of Jamaica
- Bail Act
- Charter of Fundamental Rights and Freedoms (Constitutional Amendment) Act
- Domestic Violence Act
- Sexual Offences Act
- Offences against the Person Act
- Child Care and Protection Act
- Disabilities Act
- Public Defender (Interim) Act
- Independent Commissions of Investigations Act

The rights protection framework in Jamaica is shaped by developments in the domestic human rights framework and the international human rights framework. The domestic human rights framework consists of laws, institutions, and mechanisms that work to secure human rights. Key among the laws is the Constitution of Jamaica (1962). The Constitution was amended in 2011 via the Charter of Fundamental Rights and Freedoms (Constitutional Amendment) Act, which guarantees the right to:

1. Life, liberty, and security of the person
2. Freedom of thought, conscience, belief, and observance of political doctrines
3. Freedom of expression
4. Seek, receive, distribute, or disseminate information, opinions, and ideas through any media
5. Freedom of peaceful assembly and association

6. Freedom of movement
7. Equality before the law
8. Equitable and humane treatment by any public authority in the exercise of any function
9. Freedom from discrimination on certain grounds: being male or female, race, place of origin, social class, color, religion, or political opinions
10. Privacy
11. Have protection for every minor and free tuition at the pre-primary and primary levels
12. Enjoy a healthy and productive environment
13. Be registered as an elector and have the right to vote
14. Be granted a passport
15. Protection from torture, or inhuman or degrading punishment or other treatment
16. Freedom of the person
17. Protection of property rights
18. Due process
19. Freedom of religion

Where the rights of any person are being violated or are likely to be violated, that person may apply to the Supreme Court for redress. People living with HIV and members of key populations who experience rights violations within the context of HIV may seek constitutional relief where the violation falls under any of the categories listed above. Within the context of HIV, people living with HIV and key populations will have stronger protection under the Constitution if the anti-discrimination guarantees are expanded.

There are also other laws that help to protect the rights of people living in Jamaica. These laws include the entitlement to bail, protection against various forms of violence, child care and protection, and protection to people living with disabilities. There is, however, no general anti-discrimination legislation in Jamaica.

Institutions: Laws governing human rights in Jamaica do not operate in isolation. There are institutions and mechanisms that give effect to these laws and that allow citizens to have the benefit of the laws and secure access to justice. These institutions include the courts, offices, and commissions of Parliament and the mechanisms facilitated by these institutions. Some examples include the courts, which provide redress for the violation and likely violation of constitutional rights in section 19 of the Constitution of Jamaica; the Public Defender, a commission of Parliament established for the purpose of protecting and enforcing the rights of citizens; the Children's Advocate, a commission of Parliament established for the purpose of protecting and enforcing the rights of children; and the Independent Commission of Investigations ('INDECOM'), a commission of Parliament established in 2010 to "undertake investigations concerning actions by members of the Security Forces and other agents of the State that result in death or injury to persons or the abuse of the rights of persons" (INDECOM, n.d.).

International Human Rights Framework: Rights protection in Jamaica is also influenced by the international human rights framework. Under this framework, Jamaica has ratified key human rights treaties (Table 1), obliging the State to adhere to the terms of those treaties.[1]

Table 1. Key International Human Rights Treaties

Treaty	Year Ratified by Jamaica	Year Came into Force
International Covenant on Civil and Political Rights (ICCPR)	1975	1976
International Covenant on Economic, Social and Cultural Rights (ICESCR)	1975	1976
Convention on the Elimination of All Forms of Racial Discrimination (CERD)	1971	1969
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)	1984	1981
Convention on the Rights of the Child (CRC)	1990	1990
International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families	2008	2003
Convention on the Rights of Persons with Disabilities	2007	2008

There is also the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1987), which prohibits torture and other cruel, inhumane, and degrading treatment. Although Jamaica has not ratified this treaty, international laws against torture are still binding for Jamaica.

Further, the Inter-American Human Rights System applies to Jamaica as a Member State of the Organization of American States. Jamaica ratified the 1978 American Convention on Human Rights and is subject to the Inter-American Commission on Human Rights, which has a mandate to promote respect for and defense of human rights in the region. Jamaica has not, however, accepted the jurisdiction of the Inter-American Court on Human Rights. The Inter-American Commission on Human Rights' 2012 *Report on the Situation of Human Rights in Jamaica* paid significant attention to the issue of HIV. The Commission made recommendations to strengthen protections for people living with and vulnerable to HIV, which focused on reducing discrimination, improving access to and quality of healthcare, and improving access to justice through legislative reform and specialized training (Inter-American Commission on Human Rights, 2012).

[1] Treaties are described herein by their names and year of entry into force.

3. Social Contracting Analysis

3.1 Descriptive Section

Purpose:

1. Determine the existing relationship between the government and CSOs, in general, and in the health sector, in particular
2. Determine the current level of Global Fund funding to the State and the existing grants and allocations to CSOs

Legislation reviewed:

- National Health Services Act
- National Health Fund Act

3.1.1 Overview of Health System

Health services in Jamaica are delivered through the public and private sector. In its latest Strategic Business Plan, the MOH&W explained that within the public sector, health services are delivered through a network of primary, secondary, and tertiary healthcare facilities comprising 25 hospitals, of which 23 are classified as types A, B, C, and specialist, in accordance with bed capacity and the services offered. Quasi-public sector hospitals operate within a private sector healthcare market and primary healthcare services are provided through a network of 317 health centers located island-wide (MOH, 2014).

The health sector saw major reforms in 1997 with the enactment of the National Health Services Act (1997), which gave effect to the decentralization of health service delivery and the creation of the four Regional Health Authorities, to which responsibility for the operational management for healthcare delivery in the public sector was transferred (MOH&W, 2017). The four Regional Health Authorities serve the 14 parishes, as follows:

- North East: Portland, St. Mary, St. Ann
- Western: Trelawny, St. James, Hanover, Westmoreland
- Southern: St. Elizabeth, Manchester, Clarendon
- South East: St. Catherine, Kingston, St. Andrew, St. Thomas (MOH, 2014)

However, this administrative reform has not translated into improved service delivery, and until 2017, the health reform policy was not effectively evaluated. One major finding of a recent audit of the public health sector is that there have been gaps in leadership and governance (MOH&W, 2017). The MOH&W *Vision for Health 2030—Ten Year Strategic Plan* pointed out that deficiencies in the stewardship and leadership capacity of the MOH&W were recently highlighted by the Pan American Health Organization and the World Bank (Pan American Health Organization, 2017; World Bank, 2017). These deficiencies include inefficient health planning, weak ability to develop evidence-based policy and monitor outcomes, an ineffective structure of the Regional Health Authorities, and outdated service-level agreements (MOH&W, 2019c).

3.1.2 Health Financing

Jamaica's health system is challenged by decreasing fiscal space due to low economic growth and a high debt burden (MOH&W, 2019c). Like many countries, Jamaica faces a health financing dilemma in which there is a resource gap between the demand for healthcare services and the cost of providing those services versus the available resources. This is a key acknowledgment in *Vision for Health 2030*. Jamaica also recently published the *Ten Year Strategic Plan 2019–Vision for Health 2030,* which lists "increased and improved health financing with equity and efficiency" as a strategic goal. Jamaica's current public expenditure in health represents 3.47 percent of the GDP, of which the MOH&W is responsible for 97 percent. This is financed primarily through taxes. The MOH&W has pointed out that 6 percent of the GDP as public expenditure in health is a useful benchmark and a necessary condition to achieve universal health. Therefore, Jamaica needs to close that 2.53 percentage point gap with the international benchmark (MOH&W, 2019c). One of the strategic outcomes with respect to Strategic Goal 3 is improved efficiency in how funds provided to the public health sector are allocated and utilized for the delivery of healthcare services. Strategic actions in this regard are (1) establishing a performance-based budgetary allocation mechanism in the public health sector; (2) strengthening the MOH&W's stewardship of the health sector, oversight, transparency, accountability, and interventions to reduce wastage of financial resources; and (3) strengthening the systems for financial management, budgeting, auditing, planning, monitoring, and evaluation.

Health infrastructure challenges include a lack of adequate lab equipment in hospitals and health centers, thereby affecting monitoring and diagnosis; inadequate space in some hospitals and health centers because of the growing population's size and changing demographics; poor maintenance of diagnostic equipment; excessive service needs for noncommunicable diseases; high utilization of some health facilities; high demand and utilization of accident and emergency departments; occupancy levels of medical beds in excess of 90 percent; and the deterioration of some buildings (MOH&W, 2019a). These challenges affect the State's capacity to provide quality healthcare. For example, monitoring and diagnosis are affected by inadequate lab equipment, and the high burden at the hospitals and health centers serves to discourage vulnerable groups who feel marginalized and alienated from accessing services in these spaces.

One major concern in the health-financing dilemma is how to provide some measure of protection for those in the population who are most vulnerable. To address this, the National Health Fund Act (2003) was enacted. The National Health Fund Act established the National Health Fund as a body corporate, which was charged under section 5 with "providing health benefits for residents with specified diseases and specified medical conditions" and "implementing a national health insurance plan or such other schemes of insurance," among other things. The National Health Fund has been providing some health benefits to people with specified chronic conditions by subsidizing their medications; however, it has not yet put in place a national insurance plan. In May of 2019, however, the MOH&W introduced the *Green Paper on National Health Insurance Plan (NHIP) for Jamaica*. The NHIP is presented as a step towards universal health, and it aims to provide appropriate levels of access, coverage, and financial protection to the Jamaican population (MOH&W, 2019b). While HIV and STI screenings are expressly included in the NHIP benefit package, there is no reference to nonclinical interventions for people living with HIV, which are essential to improved health outcomes among this population (MOH&W, 2019b).

3.1.3 Funding of National HIV Response

The national HIV and AIDS response is funded by the Government of Jamaica, the Global Fund, and USAID (see Table 2). A substantial portion of the funding comes from donor agencies. The National HIV/STI/TB Unit reports that since 2013, the contributions of the Government of Jamaica have increased significantly, representing an investment in a more sustainable national response. The budgetary contribution for the HIV and AIDS response in 2017 was J$1.95 billion, with the Government of Jamaica contributing J$765.38 million of that amount (MOH, 2017). For the 2019–2020 estimates, J$864,595 million was approved for the MOH&W's HIV and AIDS Control Services. The revised estimate for 2018–2019 was J$869,197 million.[2]

Table 2. Funding for National HIV Response

	Amount (USD)-2017/2018	Amount (USD)-2018/2019	Amount (USD)-2019/2020	Data Source and Year
Estimated expenditure on HIV (Global Fund and USAID)*	8,328,206.54	8,740,273.15	6,212,073.03	Audit Reports for 2017/2018 & 2018/2019 Government of Jamaica estimate of expenditure for 2019-2020
Estimated expenditure on HIV (government contribution)**	3,216,849.43	2,215,762.56	5,564,417.69	Report to the Government of Jamaica (2017/2018 & 2018/2019) Estimate of expenditure for 2019/2020

Source: Information obtained from the MOH&W during consultations, June 2019
* The MOH&W has indicated that spending is not to be aligned to the budget year of the donors, as expenditure will span more than one donor budget period.
** The MOH&W has indicated that the expenditure is for the period April - March of the respective year. This amount is earmarked HIV expenditure - it does not include what is spent by the wider Ministry of Health, e.g., human resource costs for service providers and other government ministries, departments, and agencies.

From 2004 to September 1, 2019, the Global Fund, as the largest donor, awarded US$96,436,081.54 to Jamaica for HIV and AIDS and of that amount has committed US$89,599,950.51. The total amount the Global Fund has disbursed to Jamaica over this period is US$86,782,851.39 (Global Fund, n.d.). The current grant agreement with the Global Fund is for US$12.03 million and is to be implemented over a three-year period from January 2019–December 2021. The project is in its first year of operation, and the activities are being undertaken by 24 implementing stakeholders along with the MOH&W as the principal recipient. The Global Fund Year 1 has a budget of US$4,274,302. Of the Year 1 budget, US$2,126,139 will be spent at the principal recipient level, while the remaining US$2,141,163 are being implemented by the subrecipients, all of which are CSOs.[3] CSOs deliver services pursuant to the

[2] 2019-2020 Jamaica Budget Head 42000 Ministry of Health Budget 1- Recurrent
[3] Extracted verbatim from the Ministry of Health – Principal Recipient - First Quarter Progress Report, obtained from the Country Coordinating Mechanism

implementation agreement between the MOH&W and the subrecipients.[4] The U.S. President's Emergency Plan for AIDS Relief (PEPFAR)/U.S. Agency for International Development (USAID) and Global Fund support activities and interventions that target key populations and people living with HIV, while the Government of Jamaica is responsible for targeting the general population as well as key populations and people living with HIV (MOH, 2017). The level of Global Fund Support to civil society is detailed in Table 3.

Table 3. Level of Global Fund Support to Civil Society

Component: HIV	Current Grant	Previous Grant
# of organizations receiving service delivery subgrants	13	10
# of international organizations	2	2
# of local organizations	0	0
# of nonprofits	13	10
# of private companies	0	0
Target population(s) of service delivery	3	3
Functions/types of service delivery under subgrants	Prevention, treatment, human rights	Prevention, treatment, human rights

Source: Information obtained from the MOH&W during consultations, June 2019

3.1.4 Transition and Sustainability of HIV Financing

The *Transition Preparedness Assessment Report on Jamaica's HIV/AIDS Program Transition from Donor Support* found that while a transition sustainability plan has not yet been developed, the Government of Jamaica has been incrementally absorbing HIV/AIDS costs.[5] It noted that the government committed to increased financing of treatment and laboratory costs beginning in 2016. In transitioning the ARV drug costs to the government budget, the costs are to be absorbed as follows:

- 30 percent of 2016 costs, equivalent to US$380,000
- 50 percent of the 2017/2018 costs, equivalent to US$740,000
- 70 percent of the 2018/19 costs, in the amount of US$1,270,000

[4] Information obtained from the MOH&W during consultation, June 2019

[5] In accordance with definitions used in the Global Fund Sustainability, Transition and Co-financing Policy. Board Decision. GF/B35/04 – Revision 1. 35th Board Meeting. 26–27 April 2016, **transition** is understood as "the mechanism by which a country, or a country-component, moves towards fully funding and implementing its health programs independent of Global Fund support while continuing to sustain the gains and scaling up as appropriate." **Sustainability** is understood as "the ability of a health program or country to both maintain and scale up service coverage to a level, in line with epidemiological context, that will provide for continuing control of a public health problem and support efforts for elimination of the three diseases, even after the removal of external funding by the Global Fund and other major external donors."

- Full absorption of ARV costs in 2019/2020

In transitioning laboratory reagents and supplies for viral load and CD4 testing to the Government of Jamaica budget, the costs are to be absorbed as follows:

- 50 percent of the 2017 costs, amounting to US$340,000
- 50 percent of the 2018 costs, amounting to US$470,000
- Full absorption by 2019/2020 (Curatio International Foundation, 2016)

The report highlighted that the transition preparedness assessment in Jamaica started prior to the transition from Global Fund funding. To ensure a smooth and full transition of the HIV national response from external support to country ownership, the MOH&W and Planning Institute of Jamaica appealed to UNAIDS to support the transition preparedness process in Jamaica. The Government of Jamaica assigned the Planning Institute of Jamaica, in close partnership with MOH&W, to lead and coordinate Jamaica's transition and sustainability response. The engagement of the Global Fund and USAID in the transition preparedness process from its initial phase was also highlighted as an advantage for Jamaica with regard to its transition preparedness (Curatio International Foundation, 2016). The transition preparedness assessment singled out system-wide and program-level bottlenecks that may impede sustainability of the national HIV response in Jamaica. Jamaica was found to have a summary score of 26.92 percent, indicating that the country is exposed to **high to moderate** transition risk. One main conclusion of the transition preparedness assessment was that carefully designed transition planning is needed to ensure that public health gains achieved through the concerted efforts of the Government of Jamaica and donor-funded programs are sustained after Global Fund funding ends (Curatio International Foundation, 2016).

3.2 Legal Regulatory Framework for Registration of and Service Provision by CSOs

The legal regulatory framework was assessed to determine:

- How CSOs can register as a legal entity and work with key populations and whether any legal restrictions or barriers exist in this regard
- The health services CSOs may provide, in accordance with applicable laws, and the licensing requirements, if any
- The process for obtaining the appropriate licenses
- Whether there are restrictions on hiring practices within CSOs

Laws reviewed related to registration of CSOs:

- Constitution of Jamaica
- Companies Act
- Friendly Societies Act
- Charities Act

- Customs Act
- General Consumption Tax Act
- Income Tax Act
- Property Tax Act
- Stamp Duty Act
- Transfer Tax Act

Legislation reviewed related to service provision by CSOs:

- Food and Drugs Act (1964) and Regulation (1975)
- Precursor Chemicals Act (2005) and Regulation (2014)
- Nursing Homes Registration Act (1934) and Regulation (1934)
- Nurses and Midwives Act
- Pharmacy Act
- Medical Act
- Professions Supplementary to Medicine Act
- Dental Act

3.2.1 Registration of CSOs as Legal Entities

Constitution of Jamaica: Section 13(3)(e) of the Constitution guarantees the right to freedom of peaceful assembly and association. The protection of this right is such that it applies to all law and binds the legislature, the Executive branch, and all public authorities. The Constitution allows for redress where anyone alleges that their right to freedom of peaceful assembly and association has been, is being, or is likely to be contravened. A notable advance in the protection available under the Constitution of Jamaica is that CSOs, by virtue of the 2011 amendment to the Constitution, may now apply for redress on behalf of persons who allege that their constitutional rights are being or have been infringed.[6]

Following this framework, CSOs can be formed as legal entities. There are no legal or regulatory restrictions on forming legal entities which work to provide services for gay, bisexual men and other men who have sex with men; people who use drugs; people of transgender experience; sex workers; adolescent girls; people who are incarcerated; or people living with HIV. There are also no legal or regulatory restrictions on forming legal entities that are managed or staffed by men who have sex with men, people of transgender experience, sex workers, formerly incarcerated people, and people living with HIV. People who are incarcerated have significant limitations on their right to associate and so would not be allowed to form, manage, and staff a legal entity.

[6] Constitution of Jamaica, section 19

The Companies Act: Many CSOs are registered under the Companies Act (2005) as a "company limited by guarantee" and not having a share capital. This is done pursuant to sections 8 and 20 of the Companies Act. Registration under the Companies Act does not, however, provide a CSO with status as a charity. If the CSO is desirous of being legally recognized as a charity and having all the requisite benefits associated with a charity under the new charity framework, then the CSO must register under the Charities Act.

The process is that first the Companies Office of Jamaica provides copies of the forms to be completed. The forms may be retrieved in hardcopy, downloaded from the website of the Companies Office of Jamaica and completed, or printed from the website and completed. The website also provides guidance on how the forms are to be completed. CSOs wishing to be legally recognized under the Companies Act must submit the business registration form and the Articles of Incorporation, which sets out their organization's purpose and its internal rules. A copy of the tax registration number of a relevant officer of the CSO is usually required. After registration, the CSO is required to file certain documents with the Companies Office. If registered as a company limited by guarantee and not having a share capital, the CSO must file financial statements and an annual return with the Companies Office of Jamaica.

The Friendly Societies Act: CSOs may also register as a friendly society under the Friendly Societies Act. The Friendly Societies Act allows for the registration of three types of societies, namely friendly societies concerned with providing relief, aid, or donations; benevolent societies; and specially authorized societies concerned with the business of banking.[7] A minimum of 21 people are required to obtain registration as a friendly society. A summary of the process is as follows:

- The group elects a steering committee from among its members. The steering committee should be an odd number of people.
- The following documents are then submitted to the Department of Co-operatives and Friendly Societies:
    - Three copies of proposed rules
    - Application form duly completed along with the prescribed processing fees
    - Registration agreement duly completed and signed by the relevant officers
    - Summary of intent of group's major focus and/or project proposal, if available
    - Statement of affairs (including income and expenditure statement and declaration of assets and liabilities)
    - Written proof of the proposed location for the registered office

It is also a requirement that the steering committee of the CSO attend training in the management of its society. At the end of the prescribed training, an evaluation is done to

[7] Friendly Societies Act, section 3

determine the CSO's knowledge on the management of its society and other areas of the Friendly Societies Act (1966).[8]

The Charities Act: The Charities Act facilitates the registration of a CSO as a charitable organization. As the authority designated by the minister, the Department of Co-operatives and Friendly Societies receives, processes, and determines applications for registrations under the Charities Act.[9] The Companies Office of Jamaica is the registrar of charities. It keeps the register of all charitable organizations, duly registered under the Charities Act. This register, which includes the particulars of these organizations, for example, the names, date of registration, and registered address, may be accessed on the website of the Companies Office of Jamaica.

Tax Exemption

CSOs who register as charitable organizations are entitled to tax relief under the following acts:

- Customs Act
- General Consumption Tax Act
- Income Tax Act
- Property Tax Act
- Stamp Duty Act
- Transfer Tax Act[10]

3.2.2 Due Diligence by CSOs under the Charities Act

The Charities Act introduced new measures of accountability and due diligence for organizations that wish to be legally recognized as charitable organizations. Upon registration as a charitable organization, CSOs are mandated under the Charities Act to carry out certain duties, including keeping records and notifying the authority, i.e., the Department of Co-operatives and Friendly Societies, and with respect to its management. Under section 31 of the Charities Act, a CSO registered as a charitable organization is required to manage and invest its funds in accordance with the terms of its constitution. Further, the governing board members of the CSO are required to ensure that:

- The organization operates for the public benefit
- No part of the net income or assets of the charitable organization inures to the personal benefit of any governing board member or settlor of the organization, or of any other private individual
- Contributions of the charitable organization are applied consistently with the charitable purpose of the organization

[8] Information obtained during consultations with and via documentation from the DCFS, May 2019; also available at https://dcfs.gov.jm/Forms/DCFS%20Folded%20Brochure%20March%202018.pdf.
[9] Charities Act, section 7
[10] Charities Act, sections 14, 15

- The organization conducts its affairs in such a way as to not cause harm to, or jeopardize, the public trust and confidence in charitable organizations.[11]

3.2.3 Subventions and Registration Requirements

There is no law or policy stipulating that CSOs must be registered in order to be able to receive a subvention. Consultations with government representatives also confirmed that CSOs that are in receipt of subventions from the government are usually registered as a legal entity and had a good reputation and a "track record" of providing services in their area of expertise. However, checks were not done routinely to determine whether a CSO was registered as a legal entity.

3.2.4 HIV Service Provision by CSOs

CSOs provide more than 20 percent of all HIV-related services in Jamaica (MOH&W, 2015). CSOs provide both clinical and nonclinical services for HIV, with the majority of the CSOs providing nonclinical services consisting of counseling, psychosocial support, awareness raising, peer education, and linkage to services (MOH&W, 2015). CSOs are guided by restrictions governing the provision of health services, which require licenses and professional qualifications. The provision of services related to health in Jamaica are governed by the following laws:

- Food and Drugs Act (1964) and Regulation (1975), which are particularly relevant regarding drugs and supplies for HIV
- Professions Supplementary to Medicine Act (1965), which governs the regulation of members of professions supplementary to medicine, including medical laboratory technologists, radiographers, physiotherapists, occupational therapists, nutrition assistants, and others.
- Dental Act (1974), which governs the registration of dentists and the practice of dentistry
- Nurses and Midwives Act (1966), governing the licensing and registration of nurses to practice
- Pharmacy Act (1975), which governs the registration of pharmacists and pharmacies
- Medical Act (1976), which governs the practice of medicine and the registration of medical practitioners
- Nursing Homes Registration Act (1934) and Regulation (1934), governs the registration and monitoring of institutions and facilities concerned with nursing care on any premises with few exceptions. By virtue of its definition of nursing home in section 2, this Act extends to the premises of CSOs used to provide nursing care.

[11] Charities Act, section 29

3.3. Legal and Regulatory Framework for the Funding of CSOs from the Government Budget

The legal and regulatory framework for the funding of CSOs from the government budget was assessed to determine:

- Laws, regulations, and guidelines which govern government procurement of goods and services
- Whether and how CSOs can be funded from the national budget and whether there are any restrictions on contracting CSOs to provide services related to HIV or key populations
- The procurement practices of government, as well as rules and procedures where government contracts with CSOs or where government funds CSOs from the national budget
- Mechanisms in place to allow for transparency, accountability, and safeguards from corruption

Laws and policies reviewed:

- Constitution of Jamaica
- Betting, Gaming and Lotteries Act
- Contractor General Act
- Financial Administration and Audit Act
- Public Bodies Management and Accountability Act
- Public Debt Management Act
- Public Procurement Act
- Revenue Administration Act
- Executive Agencies Act

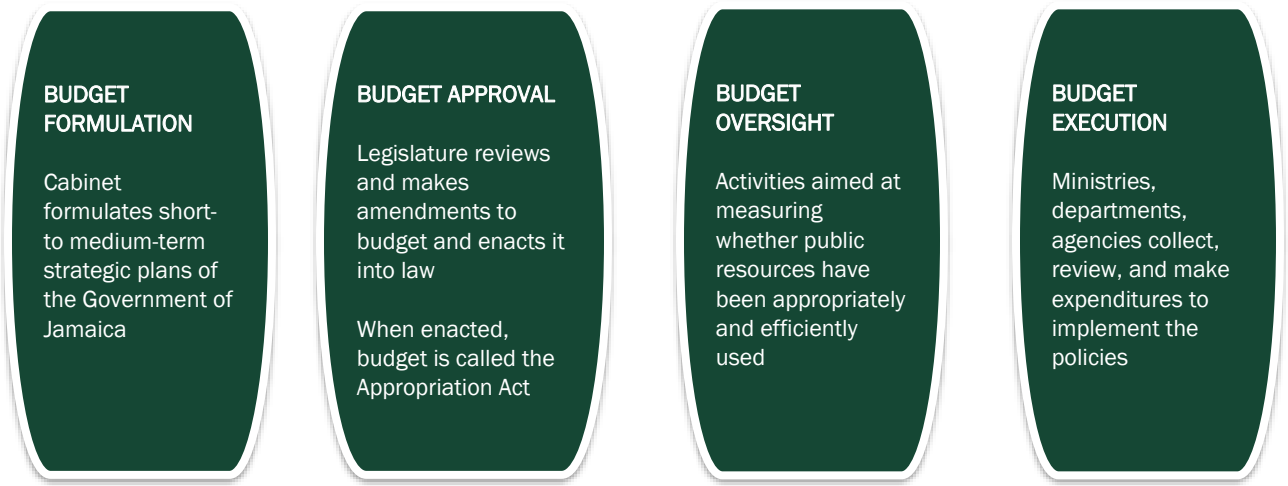
3.3.1 Budgeting Framework and Process

All withdrawals and expenditure from the government budget are governed by the Constitution of Jamaica (1962) and other laws which set out the rules regarding the public financial management and operations of the Government of Jamaica. Chapter VIII of the Constitution of Jamaica deals with the Consolidated Fund into which all revenues of Jamaica must be paid; estimates; authorization of expenditure; Contingencies Fund; public debt; and the functions and tenure of the auditor general.

The Financial Administration and Audit Act (1959) governs the control and management of the country's public finance. It sets out the laws specific to the consolidated fund, contingency funds and other funds, loans and advances, government accounts, audits, government property, public bodies, and the fiscal responsibility framework. The act has been amended over time and is supplemented by regulations, instructions, and guidelines. Also of relevance is the Public Bodies Management and Accountability Act and Regulations, which focus on the governance

framework and financial management of public bodies. This act outlines the responsibilities of public bodies regarding corporate governance and accountability.

Figure 1. The Budget Process Cycle



Adapted from MOF&PS, 2019

Budgeting is governed by several laws, the primary of which is Chapter VIII of the Constitution of Jamaica, which provides for the authority of the finance minister. Other laws governing budgeting include the Financial Administration and Audit Act and accompanying regulations that set out the financial framework of government, the Public Debt Management Act, which speaks to the obligation of the finance minister to efficiently manage the public debt, the Revenue Administration Act, which provides the framework for tax administration, the Public Bodies Management and Accountability Act and Regulations, which set out the financial and governance framework for public bodies, and the Executive Agencies Act and accompanying instructions that set out the financial framework of executive agencies.

The budget cycle consists of four main processes as detailed in Figure 1: (1) budget formulation, (2) budget approval, (3) budget execution, and (4) budget oversight. While CSOs contribute to the proposals and negotiations for grants and funding from international donors, they are not involved in the budget process for the Government of Jamaica or the MOH&W, whether for HIV or otherwise.[12]

3.3.2 Public Procurement Framework and Contracting of CSOs for HIV-Related Services

Public Procurement Framework: Procurement of goods, works, and services by government entities is governed by the Public Procurement Act enacted in 2015 and coming into effect on April 1, 2019. It sets out the obligation of the procuring entities in government to act in accordance with the provisions of the Act, and it provides the methods by which these entities can procure goods, works, and services. These methods are open bidding, restricted bidding, and single-source procurement. Section 9 establishes the Public Procurement Commission,

[12] Communication from representative of the Ministry of Health and Wellness, July 2019

which is broadly responsible for ensuring prudence in the use of public funds, promoting efficiency and integrity in the public procurement process, and ensuring transparency, fairness and equity in the registration of persons, firms, and entities under the Public Procurement Act and the award of procurement contracts. Specific functions of the Public Procurement Commission include approving and endorsing the award of procurement contracts of a value above the Tier 1 Limit; registering, classifying, and approving people, firms, or entities as suppliers; and establishing and maintaining a register of suppliers. As of April 1, 2019, the Public Procurement Commission replaced the National Contracts Commission.

Also of relevance is the Contractor-General Act (1983), which established a Commission of Parliament known as the Contractor General. Under the act, the Contractor General is concerned with the monitoring of the award and implementation of government contracts to ensure that the contracts are awarded on the basis of merit, that they are awarded and terminated without impropriety or irregularity, and that each contract is implemented in accordance with its terms.

Complementing this legal framework for public procurement of goods, works, and services and the award of government contracts is that on matters of all projects, the Public Investment Management Secretariat was recently established to administer the new Public Investment Management System (PIMS). PIMS aims to "streamline the preparation, appraisal, approval and management of all Government projects in Jamaica, regardless of the sources of funding, the type of procurement or implementation method used" (MOF&PS, n.d.). PIMS was established in 2014 through amendments to section 48J of the Financial Administration and Audit Act. PIMS is intended to ensure that the government receives "value for money, and over time, sustained economic growth and development from each project that is implemented" (MOF&PS, n.d.). During the stakeholder consultations, key informants in government often referenced PIMS in explaining that in doing business with the Government of Jamaica, the government must be satisfied that CSOs are able to provide value for money.

Contracting CSOs: The State has long recognized the important role that CSOs play in the national HIV response. It has described their contribution in the areas of community mobilization, community research, social protection, and accessing vulnerable groups as invaluable, and there is a new thrust toward increasing financial support via CSOs to maximize efficiencies and engage key population groups (MOH&W, 2015). At present, the Government of Jamaica does not contract CSOs to provide HIV-related services. This notwithstanding, the government has a record of contracting nongovernmental organizations inclusive of CSOs. This is evident when examining the operations of the Jamaica Social Investment Fund, which was established in 1996 as a component of the Government of Jamaica's national poverty alleviation strategy. The Jamaica Social Investment Fund often issues requests for bids to private sector institutions and nongovernmental organizations for the provision of services.[13]

There are no specific restrictions to CSOs being contracted from the government budget, nor are there any specific restrictions to CSOs who are being funded by the government budget or who

[13] For information about one such recent request for the provision of training services for young adults from target communities, see the Jamaica Social Investment Fund Request for Bids for the Provision of Alternative Livelihood Training Services in the Blue Economy, available at: https://www.jsif.org/sites/default/files/Ad%20-%20REOI%20-%20%20Blue%20Economy.pdf.

are contracted by the government to work among gay, bisexual, and other men who have sex with men; people who use drugs; people of transgender experience; sex workers; incarcerated people; adolescent girls; and people living with HIV to provide HIV services. There are also no specific restrictions on the government contracting CSOs comprising gay, bisexual, and other men who have sex with men; people of transgender experience; sex workers; formerly incarcerated people; or people living with HIV. Save for restrictions that apply generally, there are no legal or regulatory restrictions on activities that can be carried out by CSOs that are funded or contracted from the government budget and working on HIV.

There are no restrictions in the Public Procurement Act and regulations which are specific to CSOs generally or to CSOs working on HIV or with key populations. In summary, there are three main requirements: the CSO must be registered as a legal entity; the CSO must be able to demonstrate that they have paid all relevant taxes, and the CSO must be a supplier if so required under the Public Procurement Act. Where a CSO is registered as a legal entity and consequently recognized as a legal person under the law, that CSO can become a supplier under the Public Procurement Act. Many CSOs currently providing HIV-related services are already registered under the Companies Act or the Friendly Societies Act. They have legal personhood and are recognized legal entities. To participate in public procurement, as a supplier of services to the Government of Jamaica, that CSO must be registered as a supplier or must be recognized as an "approved unregistered supplier" in accordance with section 15. This requirement generally applies, with two exceptions: (1) the procurement is being done by international competitive bidding, or (2) the procurement is being done by a single-source procurement whereby the procuring entity invites only one organization to provide services, for example, in accordance with the stipulations under section 25 of the Public Procurement Act.

The Public Procurement Regulations, 2018, Section 17, suppliers providing services to the Government of Jamaica must demonstrate that they have paid all taxes. Proof of tax compliance is usually a valid tax compliance letter.

3.3.3 Subventions

Applications for subventions are dealt with at the ministry level. The applications are not specifically submitted to the MOF&PS for consideration. While no specific process or procedure could be identified, it was pointed out that it is up to each ministry to determine which CSO it wishes to provide a grant or subvention to, if any. Upon making this determination, this information is included the ministry's budget, which would then be submitted to the MOF&PS for consideration.[14] Representatives in the MOH&W were unable to confirm whether subventions were being provided to other CSOs focused on health services or diseases that did not include HIV. As to the mechanism under which subventions have been provided in the past, it was explained that there is and was no formal mechanism for the provision of subventions and that this has usually been done on an ad hoc basis.

Of note is the Culture, Health, Arts, Sports and Early Childhood Education (CHASE) Fund, which was established in 2002 under the Betting, Gaming and Lotteries Act (1966). Monies collected in accordance with the Act regarding gaming machine licensees and lottery licensees are deposited into this fund and are allocated to the areas of health, sports, early childhood

[14] Information obtained from stakeholder consultations with the MOF&PS, May 2019

education, and culture. Twenty percent of the allocation goes to health, 40 percent to sports, 25 percent to early childhood education, and 15 percent to arts and culture (Betting, Gaming and Lotteries Act, 1966, section 59G). As of April 1, 2017, CHASE receives its resources via the Consolidated Fund (CHASE, 2018). The CHASE Fund is governed by the Board of Directors approved by the Sector Minister, subsector Committees of the Board, and the Management Team. For the 2017–2018 financial year, the CHASE Fund disbursed JM$1.2 billion. The amount spent on the health sector during this period was JM$489.3 million. Spending in the health sector is generally used for equipping and upgrading health facilities, and supporting initiatives concerned with healthy lifestyle choices. NGOs inclusive of CSOs can apply for funding for health-related initiatives. For the 2017–2018 financial year, disbursements were made for disability sensitization workshops, health screenings and sexual abuse workshops, medical tests, and breast cancer screening (CHASE, 2018).

Organizations wishing to receive funding from CHASE are required to submit a project proposal.[15] The project proposal for health requires the applicant to provide the following: basic information such as project title, name of the organization, and contact information; applicant information, including the details of the type of organization and its history inclusive of its registration particulars,[16] its purpose, management structure, and major source of operating budget, as well as the main achievements of the organization and the major projects undertaken over the past five years; project category, whereby the organization is required to choose from a list of categories; project summary; and a detailed implementation schedule and budget. Applicants can submit and review the status of the application online.

It is important to note that the organization does not directly receive the money from the CHASE Fund. Rather, the CHASE Fund settles the respective invoices or makes the payments on behalf of the organization. Organizations are required to submit reports detailing their progress with the projects and accounting for the funding received.[17]

3.3.4 Tax and Status Implications of Social Contracting

The potential tax and status implications of social contracting on CSOs arose as issues of concern during the stakeholder consultations. The key concern was whether CSOs, which are registered as charities, would lose the tax exemptions and charity status they currently enjoy should they be contracted by the government to provide HIV-related services. The answers to this concern lie in the provisions of the Charities Act, which make it clear that an organization does not lose its charitable status merely because it is receiving income. Rather, what the organization must ensure is that no part of the net income or assets of the charitable organization inures to the personal benefit of any governing board member or settlor of the organization, or of any other private individual; the contributions of the charitable organization are applied consistently with the charitable purpose of the charitable organization; and the organization continues to operate and manages and invests its funds in accordance with the terms of its constitution.[18]

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[15] For more information, see the CHASE Fund Project Proposal Outline Health Form, available at: https://chase.org.jm//wp-content/uploads/2018/03/HealthGuidelines.pdf.
[16] The applicant does not have to be registered as a legal entity in order to receive funding.
[17] Information obtained via teleconference with CHASE Fund representative, September 2019
[18] Charities Act, sections 29, 31

Regarding the taxes payable on the income earned from the services provided to the government, the CSO would file its usual returns and financial statements, and the relevant authorities would make a determination as to the taxes payable. Once the CSO can prove its compliance with the requirements of the Charities Act, it continues to be entitled to the usual exemptions under the relevant laws.

3.4 Planning Service Provision by CSOs

Planning service provision by CSOs was assessed to determine:

- How CSOs are envisioned or referenced in national plans for HIV
- How CSOs are facilitated or whether CSOs are involved in the budget development process

Sources reviewed:

- Vision for Health 2030—Ten Year Strategic Plan 2019
- Revised National HIV Policy 2017
- National Integrated Strategic Plan for Sexual and Reproductive Health 2014–2019

3.4.1 Referencing CSOs in National HIV Plans, Strategies, and Policies

The Government of Jamaica has identified its collaboration and partnerships with civil society entities as a major strength of the HIV response. This multisectoral response was said to be evident at the national and site levels, where multisectoral committees and technical working groups have been established to manage the design, planning, development, and implementation of all major events and innovative interventions. A commitment was made to strengthen the collaboration and referral mechanism between the CSOs and Regional Health Authorities (MOH, 2017).

CSOs provide more than 20 percent of HIV-related services in Jamaica (MOH&W, 2015). They deliver services and participate in the design and implementation of the HIV response via the *National Integrated Strategic Plan for Sexual and Reproductive Health and HIV 2014–2019,* and more specifically, via the implementation agreement between the MOH&W and the subrecipients of funding from the Global Fund.[19]

All major plans, strategies, and policies identify roles and activities for CSOs, some with less specificity than others. There is room for improvement in this regard. The *Revised National HIV Policy 2017* specifies roles and activities for CSOs in the implementation of the policy, as follows:

- CSOs will partner with the government to implement various aspects of the national response, ensure that the government fulfills its roles and responsibilities, and be involved in sustained advocacy for the protection of the rights of all Jamaicans, in particular, the rights of key and vulnerable populations.

[19] Information obtained from the MOH&W, June 2019

- CSOs will develop and implement programs and activities for sexual and reproductive health (SRH) and HIV and AIDS prevention, treatment, care, and support, in line with the priorities of the *National HIV/AIDS Strategic Plan 2012–2017* and the *National Integrated Strategic Plan for SRH and HIV 2014–2019*.
- CSOs will provide SRH and HIV and AIDS prevention, care, and support services that are affordable and sustainable at the grassroots level.
- CSOs will participate in national coordination activities to minimize duplication (NFPB-SRHA, 2017).

Specific roles and activities for CSOs are also defined in the *National Integrated Strategic Plan for Sexual and Reproductive Health and HIV 2014–2019*. These roles and activities span the following five priority areas: (1) prevention and SRH outreach; (2) universal access to integrated SRH, HIV, and STI treatment, care, and support services; (3) enabling environment and human rights; (4) monitoring and evaluation of the HIV, family planning, and sexual health response; and (5) sustainability, governance, and leadership.

With regard to *prevention and SRH outreach*, Output 4 specifies that CSOs will be "supported to provide integrated SRH and HIV prevention, care and support services." The key associated actions are to support the implementation of comprehensive prevention programs by CSOs and standardize linkage-to-care protocols to guide the engagement of CSOs. Regarding the *enabling environment and human rights* priority, Output 2 is: "Human Rights and Policy Monitoring by CSOs undertaken." The key strategy will include building the capacity of CSOs in legislative, policy, and service monitoring. It will also involve continued policy dialogue to engage CSOs to ensure sustained rights-based service delivery.

Given that the *National Integrated Strategic Plan for Sexual and Reproductive Health and HIV 2014–2019* ending in 2019, the MOH&W has indicated that it has initiated efforts toward drafting a new strategic plan on HIV. A steering committee has been established, a consultant has been hired to develop the strategic plan on HIV, and consultations have begun.

3.4.2 CSOs and the Budget Process

Except as provided under grant agreements with external donors, there are no separate budgets for government-implemented and CSO activities in the national HIV response. While CSOs contribute to proposals and negotiations for grants and funding from international donors, they are not involved in the budgeting process for the Government of Jamaica or the MOH&W, whether for HIV or any other issue.[20]

3.4.3 Accountability Mechanisms and Availability of Information

Guidelines defining the responsibilities that a CSO has when receiving subventions are not available to CSOs. From the review conducted and the information learned during the stakeholder consultations, there are no guidelines on the following:

- How awardees are selected

[20] Communication from representative of the MOH&W, July 2019

- Detailed programmatic and financial reporting requirements of awardees
- How decisions are made and carried out in terminating subventions
- Whether public sector funds can be used for both "core" and programmatic costs or only program costs

Subventions are done in an ad hoc manner, and no formal guidelines are given to organizations who receive subventions. There are few, if any, accountability mechanisms to ensure that the funds given are used for the purpose for which they are given. What is generally relied on are the track record and reputation of the organization and, sometimes, the long-standing relationship between the organization and the entity or ministry that has authorized the subvention.

Except for the standards set out in the relevant laws and general conditions of the contract, **no general service provision standards have been approved at the national level specifically for services provided by CSOs.** Each ministry or government agency that wishes to enter into a contract or agreement with a private entity or with a CSO usually has its internal legal department or legal officer draft the contract.

CSOs contracting with the government for the provision of services are bound by the standards and conditions as set out in the general conditions of the contract. These include a requirement that the service provider observe the "highest standard of ethics" and a prohibition against fraud and corruption offences as defined in Part VI of the Public Procurement Act (2015). The service provider is expected to act with due diligence and efficiency and to exercise reasonable skill and care in the performance of the services. The service provider is also required to carry out the services in accordance with the relevant laws. General information about public procurement regulations is available to all people and organizations that have an interest in supplying goods, works, and services to the government. These laws and regulations are available on the websites of the MOF&PS, and the Parliamentary Library. However, issues such as programmatic reporting and record-keeping obligations are not usually included.

4. Recommendations to Government, Civil Society, and Donor Partners

A successful transition from donor funding to full domestic financing of the HIV response will allow the Government of Jamaica to preserve and build upon the gains that have been made through its collaboration and partnership with CSOs. A successful transition requires the following standards:

- A clearly defined role for CSOs, with targets and budgets (including health outcome targets, clinical cascade targets, and other related targets, such as those concerned with gender, rights, and social services)
- A legal framework that facilitates CSOs' work on HIV. In some jurisdictions, this may require specific legal direction to provide funds to CSOs for service provision tasks and may require specific legal protection to protect CSOs and their staff from prosecution if carrying out the tasks defined for CSOs in the strategic plan(s)
- A contracting mechanism that provides both governments and CSOs with the tools needed so that the work can be done effectively and can be reported on both programmatically and financially to all parties' satisfaction
- A funded mechanism exists that facilitates community monitoring of the HIV response (AMPG Health, 2017).

The findings of this legal and regulatory assessment indicate that some of these standards are already in place. First, Jamaica's legal framework facilitates CSOs' work on HIV. Second, there is a contracting mechanism, as the public procurements laws and regulations are well placed to support and facilitate social contracting of CSOs. However, further work is needed to ensure that with respect to the existing contracting mechanism, both the government, on the one hand, and the CSOs, on the other, can report on the HIV work programmatically and financially. Gaps exist with regard to the remaining two standards—a clearly defined role for CSOs with targets and budgets, and a funded mechanism that facilitates community monitoring of the response.

In light of the foregoing and based on inputs from key stakeholders, it is recommended that there be:

1. **Defined role for CSOs**: It is recommended that the MOH&W define the scope of work for CSOs by costing the new HIV strategic plan to include clearly defined budgets and targets for CSO activities.
2. **Funding mechanism:** It is recommended that the Government of Jamaica/MOH&W establish a funded mechanism with annual, predictable, and adequate budget/funding that is available for social contracting.
3. **Dialogue among key government stakeholders:** It is recommended that key representatives of the MOF&PS, MOH&W, and Department of Co-operatives and Friendly Societies (DCFS) discuss the process and implementation of social contracting in Jamaica. In this meeting, the MOF&PS could offer general sensitization on the public procurement laws and regulations, the MOH&W could share the rationale and impetus for contracting CSOs for HIV-related services, and the DCFS could share further

information on how charitable organizations in Jamaica have continued to legally retain their charitable status while providing services at a cost. The key representatives from the MOH&W, MOF&PS, DCFS, and any other agency deemed relevant by the Government of Jamaica could then assist with the respective capacity-building exercises for CSOs.

4. **Implementation of a pilot project:** A pilot social contracting project is recommended. It is recommended that prior to the implementation of the pilot project, the Government of Jamaica conduct capacity building and training for CSOs on the public procurement processes and requirements.
5. **Position statement and operating manual on social contracting:** It is recommended that there be a clear position statement on the Government of Jamaica's pursuit of social contracting and steps that will be taken towards the implementation of social contracting. In this regard, consideration should be given as to how to integrate best practices from the Global Fund model. One example of this is the use and selection of subrecipients. For the operating manual on social contracting, the manual could include a clear set of principles, expectations, and guidelines for social contracting partnerships between the Government of Jamaica and CSOs who provide HIV-related services. Substantial attention would be paid to the range of HIV prevention, treatment, and care services delivered by CSOs and the development of monitoring and accountability structures. In addition to its reliance on all the relevant laws and regulations of Jamaica, the Jamaica Social Investment Fund, for example, relies on the use of an operations manual that "acts as a guide to ensure transparency, accountability, and efficiency in project implementation" (Office of the Prime Minister, n.d.).
6. **Capacity training for CSOs:** It is recommended that there be capacity building and training for CSOs on the government procurement requirements. There will also be a need for CSOs to implement or improve upon, monitor, and maintain adequate financial and programmatic reporting structures in alignment with the objectives and indicators under the new strategic plan for HIV.
7. **Performance indicators and monitoring systems:** The development of appropriately designed performance indicators to measure the performance of CSOs and the development of systems to monitor CSO contract work is recommended. Government of Jamaica personnel will also need to be trained in this area. There should also be general training for government personnel on the implementation of social contracting in Jamaica. This training should draw on best practices in other jurisdictions and the lessons learned from social contracting initiatives across jurisdictions.
8. Finally, stakeholders may wish to think about how to ensure that the sustainability of the HIV response is built into the current discussions surrounding the proposed national health insurance plan.

Civil society organizations, government agencies, and policymakers, as well as external donors, have a role to play in the development and the implementation of social contracting.

Government agencies and policymakers can lead the social contracting process by taking the following steps:

1. Determine which funding mechanism would be the most appropriate for the country context
2. Develop transparent procurement and contracting processes
3. Ensure adequate, predictable funding is available for social contracting to CSOs
4. Develop systems to fund and monitor CSO contract work (HP+, 2018)

For their part, CSOs can support the social contracting process by taking these steps:

1. Support and engage in analysis on country ability to provide funding to CSOs
2. Advocate for transparency and accountability in the contract selection process
3. Conduct analyses on funding sources for social contracting and advocating for annual predictable financing to be included as a budget line item
4. Strengthen the organization's capacity in management, reporting, and technical monitoring and evaluation for public financing (HP+, 2018)

Finally, external donors can support the social contracting process by taking these steps:

1. Assist with the development of the social contracting funding mechanism
2. Provide the best practices globally on transparent review and accountability processes
3. Provide seed money for pilot initiatives of social contracting in-country
4. Assist CSOs and government on effective implementation and monitoring of work (HP+, 2018)

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Annex A. Details of Desk Review

Laws Reviewed:

- Constitution of Jamaica
- Charter of Fundamental Rights and Freedoms (Constitutional Amendment) Act
- Bail Act
- Betting, Gaming and Lotteries Act
- Domestic Violence Act
- Sexual Offences Act
- Offences against the Person Act
- Child Care and Protection Act
- Disabilities Act
- Public Defender (Interim) Act
- Independent Commissions of Investigations Act
- National Health Services Act
- National Health Fund Act
- Companies Act
- Friendly Societies Act
- Charities Act
- Customs Act
- General Consumption Tax Act
- Income Tax Act
- Property Tax Act
- Stamp Duty Act
- Transfer Tax Act
- Food and Drugs Act (1964) and Regulation
- Precursor Chemicals Act (2005) and Regulation (2014)
- Nursing Homes Registration Act (1934) and Regulation (1934)
- Nurses and Midwives Act
- Pharmacy Act
- Medical Act
- Professions Supplementary to Medicine Act

- Dental Act
- Contractor General Act
- The Financial Administration and Audit Act
- Public Bodies Management and Accountability Act
- Public Debt Management Act
- Public Procurement Act
- Revenue Administration Act
- Executive Agencies Act

Policies, Strategies, Plans Reviewed:

- Ministry of Health and Wellness. 2019. Vision for Health 2030—Ten Year Strategic Plan.
- National Integrated Strategic Plan for Sexual and Reproductive Health 2014–2019.
- National Family Planning Board. 2017. Revised National HIV Policy 2017.
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