

FINAL EVALUATION
AIDS/STD PREVENTION AND CONTROL PROJECT

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ACRONYMS AND FOREIGN TERMS

BCC	Behavior Change Communications
BSS	Behavioral Sentinel Surveillance
CBO	Community-Based Organization
CDC	US Centers for Disease Control and Prevention
CHARES	Centre for HIV/AIDS Research
CHED	Child Health Education Program
CI	Contact Investigator
CPE	Community Peer Educator
CSM	Condom Social Marketing
CSW	Commercial Sex Worker
FBO	Faith-Based Organization
IDU	Injecting Drug Use
JAS	Jamaica AIDS Support
JN+	Jamaica Network of Seropositives
JRC	Jamaican Red Cross
KAPB	Knowledge, Attitudes, Practices, Behaviors
MSM	Men Who Have Sex with Men
NAC	National AIDS Committee
NGO	Nongovernmental Organization
NHCP	National HIV/STD Control Program
NORAD	Norwegian Agency for International Development
NPHL	National Public Health Laboratory
PAC	Parish AIDS Committee
PAHO	Pan American Health Organization
PE	Peer Educator
PLWHA	Person Living with HIV/AIDS
SMO	Senior Medical Officer
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	US Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

CONTENTS

	Page
EXECUTIVE SUMMARY	i
I. BACKGROUND.....	1
USAID Project and the National Program.....	1
Purpose of Evaluation.....	3
Methodology.....	3
II. KEY FINDINGS AND RECOMMENDATIONS.....	5
Behavior Change and Communication.....	7
Sexually Transmitted Disease Control.....	15
Condom Social Marketing.....	28
Strengthening of Epidemiology Unit.....	29
Strengthening of National AIDS Committee.....	30
Regionalization and Parish AIDS Committees.....	32
Nongovernmental Organizations.....	33
Monitoring and Evaluation.....	37
III. FUTURE DIRECTIONS.....	40
 APPENDICES	
A: LIST OF CONTACTS	
B: SCHEDULE OF VISITS	
C: DOCUMENTS REVIEWED	
D: STATEMENT OF WORK	

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EXECUTIVE SUMMARY

The AIDS/STD Prevention and Control Project, initially authorized by the U.S. Agency for International Development (USAID)/Jamaica in August 1988, continues to record successes, as demonstrated by positive changes in risky sexual behavior, greater public awareness of, and response to, the dangers posed by HIV and sexually transmitted infections (STIs), and the strengthened technical and administrative capacity of the Ministry of Health at the central and regional levels.

Increased condom use, reduction in sexual partners, continued declines in STI rates, a possible leveling off in HIV prevalence, and greater involvement of regional, parish and community-level organizations in the national response to the epidemic have contributed significantly to the stabilization of the HIV/AIDS in Jamaica. Though the foundations for strengthened management and technical capacity have been laid, there is more building to be done if Jamaica is to take its place among the handful of countries that have successfully turned the corner in fighting this global epidemic.

The project is making progress toward its goal of reducing the increase in HIV transmission and the incidence and prevalence of STIs. Work toward reducing high-risk sexual behavior among target groups is also on track. Strengthening the Epidemiological Unit's management and technical capacity has progressed well, despite the challenges posed by the transition to a decentralized system during a downturn in Jamaica's economy. The weakest of the project interventions has been the strengthening of management capacity of the National AIDS Committee (NAC).

Strengths and weaknesses of each project component

Behavior Change and Communications (BCC): The Project has implemented a strong BCC program, which emphasizes face-to-face, interactive, culturally appropriate HIV/AIDS education. This approach updates an earlier approach that emphasized mass media BCC. There has been positive behavior change in recent years, namely high condom user rates (especially with non-regular partners); a significant decrease in the proportion of Jamaicans reporting multiple partners; and a slight rise in the median age of sexual debut. However, there has been slippage in condom user levels among females age 20 and older and some older males, and a slight rise in the proportion of women reporting multiple partners.

Recommendation: The general population should be provided with continuing education about the facts of HIV/AIDS, challenging popular myths, and implemented through radio and television campaigns. Such campaigns are needed to complement face-to-face education.

Recommendation: Sex education, including education about HIV and STIs, along with life coping skills, needs to be strengthened in the schools. Though the policy framework is in place, a better designed and agreed-upon plan for widespread and systematic implementation and monitoring is needed.

Recommendation: The delay of sexual debut and abstinence messages, promoted primarily

through schools and churches, should continue to be part of the national BCC strategy. This message should be targeted to children under age 15, perhaps as young as 10.

Recommendation: To reverse slippage in condom user levels among women age 20 and older, renewed efforts are needed to reach this group with condom promotion messages, and to influence condom adoption.

STD Control: The National HIV/Sexually Transmitted Disease (STD) Control Program (NHCP) has implemented a strong STD control component that includes syndromic management, plus an unusually effective program of contact tracing and HIV counselling and testing. As a result, prevalence and incidence (when data for the latter are available) of most STDs has declined markedly for several years. Strengthened supervision of the contact investigator (CI) program is needed, and care needs to be taken to prevent “burnout” of CIs.

Sentinel surveillance has been in place since 1990 in the same three parishes; three additional parishes were added in 1999, and, by 2000, surveillance was performed in 10 parishes total. Surveillance is also carried out in several high-risk groups and in 10 low-risk groups, some of which can serve as proxies for the general population. Quality control is maintained through links with the U.S. Centers for Disease Control and Prevention (CDC).

Recommendation: The Ministry of Health should expand its current training to include supervisors to adequately cover community peer educator (CPEs) activities on a weekly basis and relieve overburdened CIs from the informal role of overseeing the work of CPEs and volunteer peer educators (PEs).

Lesson Learned: In discussions with USAID/Washington staff, concerns were voiced that contact tracing in Jamaica and elsewhere could be a potential violation of human rights, something that leads to exposure (or "outing") by the government and may result in reprisals or stigma. Yet by all accounts, the program in Jamaica has worked well. CIs maintain trust and confidentiality, and they serve an important role and function in care and support, HIV counselling and testing, HIV prevention, and in dealing with psychosocial issues. Other countries might do well to learn from the Jamaican experience in contact investigation.

Condom Social Marketing: Programs addressing condom promotion and provision, including condom social marketing (CSM), and a BCC emphasis on condom promotion, have been successful in Jamaica. CSM was included in the recent project for 2 years, from 1997 to 1999. The project aimed to achieve a 20% increase in condom sales by the end-of-project. An islandwide network of at least 2,000 non-traditional retail outlets was established in collaboration with the National Family Planning Board. The Ministry of Health feels that a national-level CSM program is no longer needed. CSM continues at the parish level, and some PEs receive small cash stipends from profits from the sale of condoms purchased wholesale by parish. The former national CSM manager feels that problems of condom availability persist in rural areas, and that mass media promotion continues to be needed.

Epidemiology Unit: The integrated management and services approach in the Epidemiology Unit has continued to build on its successful experience under the original project agreement, supporting policy decisions and providing technical guidance for BCC and CSM, as it has for STI prevention. It has evolved into the administrative and technical center of the NHCP, with the ability to assume greater responsibility for implementing the NHCP, including the USAID-funded components.

As decentralization proceeds to take root, the Epidemiology Unit has steadily disengaged itself from the day-to-day responsibilities for either the regional or parish operations. With the reorganization of the Ministry of Health, the Epidemiology Unit has been absorbed into the larger Health Promotion and Protection Division. The Senior Medical Officer (SMO) is the Director of the HIV/AIDS/STD Program and works directly with the Regional Technical Directors and Parish Medical Officers for Health. Though surveillance is now in a separate section, the SMO is technically responsible for the analysis, synthesis and dissemination of data on HIV/AIDS.

Recommendation: Guidelines for workplan and budget development should be developed to ensure that regional priorities reflect parish and local needs.

Recommendation: An evaluation component should be required in all activities carried out at the regional and parish levels.

National AIDS Committee: The NAC remains the best qualified agency to carry out policy and advocacy functions by bringing together key stakeholders in the public and private sectors to help implement and monitor the NHCP Medium-Term Plan. Though most persons interviewed commented favorably on the “excellent” concept of the NAC, they were also quick to point out that it had been plagued by problems in the areas of public perception. The NHCP has often been mistaken as a part of the Ministry of Health. There have also been problems surrounding executive leadership and a lack of resources to build a strong infrastructure and mobilize a multisectoral response. At the central, regional, parish and nongovernmental organization (NGO) levels, failure to consolidate infrastructure can be attributed to a lack of political commitment, a poor mix or balance in active volunteers, and lack of independence from the Ministry of Health.

Recommendation: Leadership of the NAC should be classified and funded at a more senior level, with the Executive Committee being more inclusive of Parish AIDS Committee (PAC) leadership and playing a more supportive role in regular operations at the national level.

Related Issues

Though not specifically delineated in the project agreements, several issues remain that have not been addressed adequately or in any systematic way, thereby weakening the response to HIV/AIDS both within this project and the national program. Key among these are: absence of a monitoring and evaluation plan and trained personnel to keep policymakers and program managers abreast of trends and outcomes; inattention to capacity building outside of the

Epidemiology Unit, especially at the regional level; an underutilization of NGOs in planning and implementation of project activities; and the absence of a training infrastructure to systematically plan, conduct and follow up on training for physicians, other health professionals, counsellors, and managers in both the public and private sectors.

Recommendation: Annual workplans for monitoring and evaluation should be developed, to include training and technical assistance in the Epidemiology Unit (its successor under reorganization) and Regional Health Offices, technical coordination of external contracts for data collection and analysis, and technical collaboration on internal data collection, reporting and analysis.

Recommendation: A formal monitoring and evaluation unit should be established, with a senior-level post to coordinate internal and external data collection and analysis; Behavioral Sentinel Surveillance (BSS) Surveys; Knowledge, Attitudes, Practices and Behaviors (KAPB) Surveys; and other quantitative and qualitative surveys and special studies, and to provide ongoing technical assistance and training to the other Epidemiology Unit components (their successors under reorganization) and Regional Health Offices.

Recommendation: Private physicians should be encouraged and offered incentives to participate in well-designed and systematically presented training and orientation programs in syndromic management of STIs, voluntary counselling, testing and treatment of HIV and AIDS patients, drug detailing and alternative therapies

Recommendation: Health care providers should be encouraged and offered incentives to participate in well-designed and systematically presented training and orientation programs in syndromic management of STIs, and voluntary counselling, testing and referral of HIV clients.

I. BACKGROUND

AIDS/STD PREVENTION AND CONTROL PROJECT DATA

Project Approved (AIDSCAP)	August 1988
Project Amended	May 1997
Project Evaluated	November 1999
Project Amended (Epi Unit/MOH)	September 1996
Project Assistance Completion Data	August 2001
	(US \$ millions)
Total Project Funding	10.115
Amount Obligated	9.244
Amount Committed	8.907
Accrued Expenditures	8.519

THE USAID PROJECT AND THE NATIONAL PROGRAM

The purpose of the **AIDS/STD Prevention and Control Project**, when it was launched in August 1988 under AIDSCAP, was to improve the health of the Jamaican people by reducing HIV/STD transmission, the incidence and prevalence of STIs, and high-risk sexual behavior among target groups in Jamaica. In 1992, the project's objective was amended to refocus activities on strengthening the Ministry of Health's capacity for managing the HIV/AIDS/STD surveillance and research, behavior change and communications (BCC), and social marketing components of the national HIV/STD prevention and control program. In the current phase, which began in August 1996, there are three areas of technical assistance interventions: one emphasizing delivery of technical services and two concentrating on management strengthening and organizational development. The technical service interventions are:

1. **STD Control** to reduce STDs as a cofactor in the transmission of HIV infection to individuals at high risk;
2. **Behavior Change and Communications** to address lifestyle issues such as lack of condom usage in regular sexual relationships and the relatively high level of multiple partnerships, especially casual relationships; and,
3. **Condom Social Marketing** to promote sustained condom use.

These interventions are complemented by two additional management strengthening and organizational development interventions to:

1. Institutionalize effective management and technical capacity within the **Epidemiology Unit** in the Ministry of Health; and,
2. Strengthen the **National AIDS Committee (NAC)** in the area of policy analysis and formulation to influence policy formulation and legislation on HIV/AIDS issues in Jamaica.

The major differences between project activities from 1988 to 1996, and since 1996 are:

1. Expanding BCC locations from the Kingston-St. Andrew area to 12 additional parishes, thereby complementing the STD clinics already established under the national program;
2. Decentralizing management of the project's BCC interventions to regional and parish offices, with the Primary Health Care Division responsible for administration; and,
3. Making the Epidemiology Unit responsible and better able to manage USAID resources for the STD surveillance and research, BCC, and social marketing components of the national program, replacing AIDSCAP

The **National HIV/Sexually Transmitted Infection (STI) Control Program** (NHCP) mission, as described in the **Medium Term Plan 1997-2001**, is to develop an effective national response to HIV/AIDS/STDs in Jamaica by forging multisectoral partnerships at the national and parish levels, to reduce HIV/AIDS/STD incidence in the Jamaican population, and to mitigate the impact of the AIDS epidemic.

The **objectives** are:

- To guide the national intersectoral and multilevel HIV/AIDS/STD response;
- To promote the growth and development of the multisectoral National AIDS Committee and Parish AIDS Committees to sustain the program;
- To position the Epidemiology Unit of the Ministry of Health as the central coordinating body facilitating program implementation at the parish level;
- To stimulate program leadership at the parish level; and,
- To facilitate the expansion and development of parish STD/HIV program workplans, which reflect integrated and holistic services and approaches.

The **components** of the national program are: policy, planning and management; epidemiological surveillance; research; laboratory; STD control and prevention; BCC; condom promotion; training; counselling; comprehensive care; social support; and evaluation. The **target populations** are: persons with HIV and their partners; persons with STDs; commercial sex workers; men who have sex with men; youth; inner-city communities; sexually active adults; and the general population. Target groups are reached through the following vehicles: commercial sector; health care providers; policymakers; community leaders; church leaders; teachers; and artists.

PURPOSE OF THIS EVALUATION

The principal objectives of the evaluation were to review the performance of USAID-funded activities from 1996 to present to:

1. Assess the strengths and weaknesses of the project design and lessons learned; and
2. To provide recommendations that would strengthen current approaches and could be implemented in the short-term but designed for the long-term.

METHODOLOGY

The evaluation team was composed of three persons, including an evaluation specialist/team leader, a BCC specialist, and a public health specialist. Prior to the beginning of the evaluation and throughout the evaluation process, team members reviewed documents, project papers and reports from USAID/Jamaica and the Ministry of Health, and studies and research papers related to HIV/AIDS/STDs in Jamaica. They interviewed personnel from USAID/Washington and USAID/Jamaica, senior officers in the Jamaican Epidemiology Unit, and other senior officials in the Ministry of Health in Kingston. These joint and individual meetings focused on project performance (both perceived and documented), availability of and access to information resources and sources, and approaches by the Synergy Evaluation Team to assess achievement of results for the intended outputs for the interventions in BCC, STD control, condom social marketing services design and delivery, Epidemiology Unit management and technical skills strengthening, NAC and PAC strengthening, regionalization and centralization, and institutionalization of key project-funded posts within the Ministry of Health.

Following initial work in Kingston, the team undertook fieldwork for two weeks in Ochos Rios, Montego Bay, Mandeville, Spanish Town, and St. Andrew. Joint and individual interviews were conducted and meetings held with regional and parish health officials, representatives of other donor organizations, current and former project staff, NGOs involved in HIV/AIDS prevention and care, members of Parish AIDS Committees, current and former members of the National AIDS Committee, private firms and contractors who had conducted national and local surveys, health care providers, private physicians, sex workers, taxi drivers and hotel workers. The purpose of the interviews was to gather information on the potential for expanded roles of regional health agencies, NGOs and the private sector, and the strengthening of care and support activities in the context of USAID and other international and bilateral donor programming beyond the focus on prevention that has dominated programming over the past 12 years.

The team returned to Kingston for follow-up technical and informational meetings with key staff in the Epidemiology Unit, and interviews with the Minister of Health, Permanent Secretary, and Chief Medical Officer. The final three days were spent on report preparation and presentation of key findings and recommendations to USAID Mission Director, Director PDM, and PHN Team members, and the MOH Director of National HIV/AIDS/STI Programs, National HIV/AIDS/STI Program Administrator, National BCC Program Coordinator, and STD Technical Advisor. (See **Appendix A for list of contacts**).

Issues discussed in these formal and informal interviews included:

- the status of BCC and HIV/STD surveillance activities and reliability of data and reports;
- trends in sexual behavior among at-risk groups, including youth and "beach boys;"
- successes in condom promotion and social marketing;
- current and potential roles of NGOs in prevention and/or care and support;
- relationships, perceived and actual, between the NAC and Parish AIDS Committees (PACs), PACs and NGOs, Regional Health Offices and PACs, and regional and central health offices;
- private sector and local level support for new initiatives;
- donor and national funding inputs and priorities;
- participation of, and support from, churches and other faith-based organizations;
- training in STI syndromic management, counselling, peer education, and management;
- stigma and discrimination and related human rights issues; and
- adolescent reproductive health and HIV/AIDS programming.

II. KEY FINDINGS AND RECOMMENDATIONS

Starting the final year of its current five-year cycle, the AIDS/STD Prevention and Control Program continues to record successes, as shown by the positive changes in risky sexual behavior, greater public awareness of, and response to, the dangers posed by HIV and STIs, and strengthened technical and administrative capacity of the Ministry of Health at the central and regional levels. The project goal of reducing the increase in transmission of HIV and incidence and prevalence of STIs is being addressed successfully, and the project's goal of reducing high-risk sexual behavior among target groups is also demonstrating successes.

USAID/Jamaica is making progress toward achieving its **Strategic Objective** of "Improved reproductive health of (Jamaican) youth," and its **Intermediate Result** of "Increased use of quality reproductive health and HIV/STD services and prevention practices." The indicators selected to demonstrate fulfillment of the project's goal are consistent with those delineated in the National HIV/AIDS Control and Prevention Program Medium Term Plan, 1997-2001:

- Annual increase in HIV prevalence reduced 50% over previous five-year phase (1991-1996)

Finding: Increase in HIV Prevalence 1991-1996 from 0.45 to 0.98 -- 110%

Increase in HIV Prevalence 1996-2000 from 0.98 to 1.60 -- 53%

Percentage Testing HIV-Positive in Sentinel Surveillance Clinics

1992	1993	1994	1995	1996	1997	1998	1999
0.45	0.21	0.60	0.55	1.96*	0.98	1.5	1.6

*The Epidemiology Unit believes the 1996 figure is higher than it should be, due to sampling.

- Improved condom access by high-risk groups at traditional retail outlets from 58% to 75% and at non-traditional outlets from 14% to 35%

Finding: Condom availability at traditional retail outlets in 2000 -- 97% to 100%

Condom availability at non-traditional outlets in 2000 -- 97% to 100%

Condom affordability - 1-year supply retails for < 2% of annual minimum wage

- Condom use by the general population on last sex with main partner increased from 40% to 50%, and with casual partner from 70% to 80%

Finding: Condom use by males at last sex with main partner in 2000 -- increase to 67%

Condom use by females at last sex with main partner in 2000 - decrease to 38%

Finding: Condom use by males with last non-regular partner in 2000 -- 76% to 78%

Condom use by females with last non-regular partner in 2000 -- 57% to 79%

Condom use by young males / females (ages 15-19) in 2000 -- 78% & 79%

Condom use by young males / females (ages 20-29) in 2000 -- 76% & 63%

- Incidence of primary and secondary syphilis reduced to 20/100,00 from 30/100,000 of general population by 1998 (there is no year specified in the Medium Term Plan)
Finding: Primary and secondary syphilis rate/100,000 decline 1997-1999 -- 14.1 to 10.5
Primary and secondary syphilis in males / females in 1999 -- 11.5 & 9.4

The USAID Project Paper also delineated two additional indicators not listed in the Medium Term Plan:

- Decrease in multiple partners by 25%
Finding: Decrease in multiple partners for males (20-29), 1996-2000 -- 36.9% to 31.8%
Decrease in multiple partners for females (20-29), 1996-2000 -- 7.0% to 5.2%
Decrease in multiple partners for males (30-39), 1996-2000 -- 32.3% to 26.1%
Decrease in multiple partners for females (30-39), 1996-2000 -- 9.3% to 7.1%
 Declines for males 14% & 19% -- for females 26% & 24%
- **Finding: Decrease in multiple partners for males (15-19), 1996-2000 -- 36.8% to 24.0%**
Increase in multiple partners for females (15-19), 1996-2000 -- 3.8% to 4.5%
 Decline for males 34% -- increase for females 18%
- Risk awareness of STD/HIV infection among 95% of youth 14-29 years of age

Increased condom use, reduction in sexual partners, continued declines in STI rates, a possible leveling off in HIV prevalence, and the greater involvement of regional, parish, and community organizations in the national response to fighting the epidemic have contributed significantly to the stabilization of the HIV epidemic in Jamaica.

Though not specifically delineated in the project agreements, several issues remain that have not been addressed adequately or in any systematic way, thereby weakening the response both within this project and the national program. Key among these are: the absence of a monitoring and evaluation plan and trained personnel to keep policymakers and program managers abreast of trends and outcomes; inattention to capacity building outside of the Epidemiology Unit, especially at the regional level; underutilization of NGOs in the planning and implementation of project activities; absence of a training infrastructure to systematically plan, conduct and follow up on training for physicians, other health professionals, counsellors, and managers and supervisors in both the public and private sectors; and the inability to generate an effective multisectoral response for making HIV/AIDS a government and development priority.

1. BEHAVIOR CHANGE AND COMMUNICATION

BCC addresses the aspects of lifestyle issues that lead to high-risk behavior, including a relatively high level of multiple partnerships, especially casual relationships, and lack of condom use in regular relationships. Project activities were directed toward achieving the following targets:

1. Condom usage increase from 70% in casual sexual encounters to 80%. Among those reporting sex with their main partner, the targeted increase is from 40% to 50%;
2. Reduction in rates of STDs among commercial sex workers (CSW) and men who have sex with men (MSM) to 20% from 32% of those surveyed;
3. Reduction in incidence of multiple partnerships, especially casual relationships, to 40% from the reported rate of 53%;
4. Increase in the awareness of dangers of infection as indicated by the number of patients at STD clinics who think that STDs are easy to cure, reduced to 40% from the present 53%; and
5. Reduction in the repeat infection rate among STD clinic patients to 50% from 65%.

Prior to 1996, BCC aimed to raise public awareness of HIV/AIDS through mass media. By 1994, 98% of Jamaicans had heard of AIDS. In 1996, 95% of men and 96% of women could name two or more methods by which to prevent HIV/AIDS. Under the current project, the emphasis shifted from mass media to face-to-face communications, and outreach to special risk groups: MSM, CSW, STI clinic attendees, informal commercial importers (ICI), the prison population, and adolescents. These are groups showing the lowest levels of positive behavior change and the highest rates of HIV infection. Community peer educators (CPEs) were employed to reach these groups. It should be noted that, in addition to the 50 CPEs working under the NHCP, there are other peer educators (PEs) working under other programs: 39 (down from an original 43) reproductive health PEs under the National Family Planning Board; an indeterminate number of volunteer PEs, some from NGOs such as the Red Cross; PEs working under Addiction Alert; and 35 contact investigators (CIs), part of whose role is AIDS preventive education .

The team found that there has been a great deal of face-to-face HIV/AIDS education since 1996. If the total contacts of CPEs are added up, together with CI contacts and those of anyone else talking to groups (such as trained or sensitized religious leaders talking to their congregations), it is evident that many Jamaicans are being reached with HIV/AIDS information. Data are available for the numbers of people reached by CPEs, including those contacted in small group sessions, as summarized in the following table. But such data are lacking for the number of people reached by various types of *volunteers*, including those in NGOs who are indirectly supported by USAID. There are separate data reported for CI contacts (although these may be underestimated).

Recommendation: The Ministry of Health should expand the current training to include supervisors to adequately cover CPE activities on a weekly basis and relieve overburdened CIs from their informal role of overseeing the work of CPEs and volunteer PEs.

Some Measures of Community Peer Educator Activity*				
Period	# Educated, trained	# Materials distributed	# Sessions conducted	# Condoms distributed
1996/97	270	35,000	NA	NA
1997/98	107,306	5,000	NA	5,277,586
1998/99	155,766	24,184	6,122	3,591,601
10/99-07/00	111,852	NA	c. 5,000	145,420
Total	375,194	NA	NA	NA

* from USAID/MOH Annual Report 1998/99 and data from MOH/BCC for period 10/99-7/00.

The BCC program has led to training of more than 375,000 persons as HIV/AIDS educators, who in turn distribute condoms and educational materials to targeted populations. Those trained or educated by CPEs during the last quarter of 2000 included persons working at or with health centers, youth centers, schools, churches, parent-teacher associations, workplaces, prisons, private medical centers, rural communities, go-go clubs and other CSW locations, and street corners or other informal settings. In addition, CIs, volunteer PEs, reproductive health PEs, and other volunteer PEs have also raised awareness, counseled, and educated many Jamaicans. The Knowledge, Attitudes, Behaviors, Practices (KABP) national survey (Hope Enterprises 2000) found that 35% of those sampled had learned something about HIV/AIDS from "direct contact," as distinct from mass media (83%).

While risk group targeting continues, a **new mass media campaign** was launched recently, after a considerable lull. It uses radio, television, billboards and posters as vehicles for education. The targets of this campaign are men with multiple partners, sexually active women, and parents of teenagers and pre-adolescents. Campaign themes include: "AIDS is in Jamaica. Let's face it together" and "Life is a Gift. Don't throw it away." The main message is: "Change your thinking, change your behavior."

School-Based BCC

The Ministry of Education and several NGOs have worked together to reach in-school youth, aged 10-19. BCC efforts have been implemented in concert with the Child Health Education Program (CHED), conducted by the Bureau of Health Education and Addiction Alert Program. The NHCP's 1998/99 Annual Report states that 63 school guidance counselors, 75 peer educators in reproductive health (in St. James alone), and 20 CHED teachers have been trained in BCC. Teachers and counselors have reached an estimated 10,000 students. Twelve Addiction Alert Peer Educators were trained in HIV/STI issues in 1999.

Jamaican schools have implemented some aspects of sex education (family life education) and life coping skills (which should include negotiation of safe sex, or not having sex) as part of the school curriculum. However, the degree to which the curriculum is actually carried out seems to depend on individual principals and teachers or guidance counselors. Many school staff feel uncomfortable

discussing sex or STIs in any manner. It helps if school staff have been trained in HIV/STIs, but this is no insurance that sex education will be taught.

Sometimes BCC peer educators or CIs or others trained under the project are invited into schools to conduct sex education, including HIV/STI education. For example, in Portland parish, 90% of guidance counselors have been trained in HIV/AIDS education, which helps make the local volunteer peer educators welcome in the schools. These PEs, in effect, do the work of teachers or counselors for them, since the Ministry of Education has mandated that schools teach life coping skills. However, these are at best one-time sessions.

There is general agreement that sex and HIV/STI education needs to be improved in the schools. Still, the program is making an impact. The majority of Jamaicans age 15-19 in the 2000 national KABP survey cited "school" as their primary source of information about HIV/AIDS and STIs, a finding supported by recent qualitative research. There have been some positive behavior changes among youth in recent years: increased condom use, a decrease in multiple partners, and a slight increase in the proportion of those aged 15-19 delaying sexual debut. Since data are not available for ages younger than 15, this should be remedied in future research and surveys, especially in view of the fact that the current mass media campaign is targeted partly to pre-adolescents.

At least one recent study of school-based programs has shown positive impact, finding that, "Over the two-year period, knowledge of at least two HIV prevention methods increased significantly ($p < .001$) among both boys (71% to 99%) and girls (70% to 94%). Many more adolescent boys reported sexual experience and recent sexual activity than girls. However, declines were reported in boys sexually experienced (59% to 41%, $p < .001$) and sexually active in the past 12 months (40% to 33%, $p = .08$). Ten percent of girls reported being sexually experienced (from 11%) and 7% sexually active (from 6%)."

Recommendation: Sex education, including HIV and STI education, along with life coping skills, needs to be strengthened in the schools. Though the policy framework is in place, a better designed and agreed-upon plan is needed for widespread and systematic implementation and monitoring.

Out-of-School Youth

The NHCP has worked through local NGOs such as the Red Cross, YMCA, YWCA, National Youth Service, and local youth clubs to reach out-of-school youth. Sixty people were trained in BCC in 1998/9, specifically in basic HIV/AIDS facts, sexuality, condom use and condom negotiation skills. Condom use has risen with this group since 1996.

Twelve Addiction Alert PEs were also trained in educating youth about the role of drug and alcohol use in STI and HIV/AIDS transmission, and are working in schools in Kingston and St Andrews. There seems to be little IDU (injecting drug use) in Jamaica, although there is much ganja (marijuana) smoking and increasing use of crack cocaine, including among CSWs, prisoners, MSMs and STI clinic attendees.

BCC Strategy

The BCC program uses a hybrid BCC approach based on a theoretical foundation that includes: Theory of Reasoned Action, Stages of Change Model, AIDS Risk Reduction Model, and Everett Rogers' Diffusion of Innovation Theory. The peer education model is linked to the last model, and in Jamaica, as in other countries, it is based on use of opinion leaders within particular groups as well as on true peers of the target audiences.

The BCC unit has been operating on the basis of a 1996 strategy document (not available to team). In the last months of 2000, a BCC strategic planning exercise was carried out, and a strategic planning document is in final preparation. The strategy planning began in-house, with BCC staff conferring with Ministry of Health health educators, as well as BCC and health education staff at the regional and parish level, along with researchers and others at the University of the West Indies. Together, an attempt was made to decide what has worked, or worked best, based on research and any other evidence. A workshop was then conducted, where participants broke into small groups on the basis of expertise in particular risk groups, e.g. youth, CSWs, injection drug users, MSMs. The BCC Coordinator feels that this was a very useful and needed exercise, because those working in BCC are not used to thinking strategically.

One BCC approach that needs more strategic planning is the "targeted intervention community" approach. This approach centers on identifying communities or populations at special risk, on the basis of research findings. The BCC Coordinator believes the development of a baseline profile—one based on epidemiologic, socioeconomic and other information—is needed before intervention takes place.

The BCC program has not been effective in reaching the MSM and bisexual communities. Program leaders acknowledge this and say they are open to suggestions as to how to better reach these hidden groups. Some NGOs, notably Jamaica AIDS Support (JAS), have done quite well in reaching men who may regard themselves as fully gay, and it has reached them quietly and discreetly. But the group, working with limited resources, has been less successful in reaching bisexual men and those living outside of major cities.

Recommendation: The next phase should place more emphasis on reaching MSM groups and should directly involve Jamaican NGOs and community-based organizations (CBOs).

BCC Sustainability

The Ministry of Health is committed to incorporating the four Regional BCC Coordinators by the end of the current USAID-supported project. Regional health departments are retaining their BCC Coordinators, budgeting for their positions for 2000 or 2001, and renaming the position Health Promoter (or in the Northeastern region, Regional Reproductive Health Officer). From interviewing three Health Promoters, as well as other informants in their regions, it seems that Health Promoters still function as BCC Coordinators, even though their responsibilities go beyond HIV/AIDS. The national BCC Coordinator feels that inclusion of Health Promoters in each region has been a major achievement in institutionalizing HIV/AIDS BCC in the government.

BCC and Research

Under the former AIDSCAP project, a considerable amount of BCC-related research was carried out. The use of non-specific, non-binding language regarding monitoring and evaluation in the 1996 project paper led to a decline in research performed since 1996. The document did not designate specific studies as deliverables within defined timeframes.

Near the end of the present project, Hope Enterprises conducted a retail audit of the condom market and a KABP survey, in late 1999 and early 2000, respectively. A behavioral sentinel surveillance (BSS) survey of high-risk groups targeted by the project was also recently completed. The BSS provides, among other things, social, economic, and lifestyle profiles of CSWs and out-of-school youth, which should help tailor outreach programs to the special situations and needs of these groups. **(Only some preliminary sections of the BSS report were available to the evaluation team).**

The Pan American Health Organization (PAHO) recently commissioned a qualitative, focus group study which was conducted by the University of the West Indies. Focus group discussions were conducted with inner-city, suburban, and rural youth. All three cohorts cited schools as a main source of information about sex, HIV/AIDS, and related subjects. Respondents also expressed views on topics such as age of sexual debut and the number of partners one ought to have. Inner-city youth were found to have views and values most supportive of multiple partners, while suburban and rural were more conservative in their views. Self-identified Christians were also more conservative. Oddly, the focus groups did not directly address HIV/AIDS or STIs. This study also provides evidence of values and attitudes supporting violence, machismo, and homophobia, which constrains more than just programs directed at MSMs; it taints all subjects related to HIV/AIDS and makes them taboo or at least controversial.

The availability of recent studies is useful for the final project evaluation. It is unfortunate that no such studies were conducted earlier in the project's lifespan, when timely revelation of issues needing to be addressed could have resulted in responsive actions. Some findings of the recent studies are reviewed below, especially as they relate to BCC inputs.

Knowledge Levels

In 1996, 95% of men and 96% of women could name two or more methods (prompted) by which to prevent HIV/AIDS. This rose to 97% of men by 2000, while the proportion of women remained at 96%. In a disturbing finding, a lesser proportion of those sampled in 2000 cited only correct methods for preventing HIV/AIDS than those in 1996. In other words, more Jamaicans were citing incorrect popular myths as modes of HIV transmission (e.g., exposure to dirty toilets, receiving a mosquito bite, touching a corpse) in the 2000 sample.

Only Correct Methods of HIV Prevention Cited		
	1996	2000
Men	47%	33%
Women	62%	44%

The BSS survey, aimed at special higher-risk Jamaicans, also found relatively high levels of belief in myths regarding HIV transmission (e.g. 56% of out-of-school youth).

These findings suggest that there is still a need for mass media campaigns to promote general education about HIV/AIDS, and that there were too few education campaigns implemented between 1996 and 2000, however successful the project was in reaching Jamaicans through face-to-face BCC strategies.

Recommendation: There is a need to provide the general population with continuing education about the facts of HIV/AIDS, challenging popular myths, through radio and television. Mass media campaigns are needed to complement face-to-face education.

Condom User Levels and Trends

There was little or no population-based survey research conducted by the NHCP after 1996, until a national KABP related to HIV/AIDS and STIs was conducted in 2000. This sample survey had a nationally representative sample of 1,498 (754 men, 744 women), age 15-49. Major findings of the 2000 KABP are as follows:

Condom use has increased slightly among youth, but has decreased among older age cohorts, as the following summary tables show.

Young Males and Females Reporting Condom Use			
<i>(in last sexual intercourse with last non-regular partner)</i>			
Males	1994	1996	2000
age 15-19	65%	74%	78%
age 20-29	85%	79%	76%
Females			
	1994	1996	2000
age 15-19	57%	71%	79%
age 20-29	79%	68%	63%
age 30-39	55%	86%	57%

Condom use with regular partners

Protection via condom use (last time) with a regular partner increased among men (from 47% in 1996 to 52% in 2000) but declined among women (from 41% in 1996 to 38% in 2000). The decline among women was reflected in all age groups. Among men, all ages recorded increases, with the exception of the 30-39 group, which declined (from 43% in 1996 to 35% in 2000).

Recommendation: To reverse slippage in condom user levels among women age 20 and above, renewed efforts are needed to reach this group with condom promotion messages, and to influence condom adoption.

Sexual Behavior, Multiple Partners

Apart from trends in condom use (see condom section), the proportion of both males and females who reported two or more partners for the previous 3-month period declined sharply in 2000, compared to 1996. There was a decrease among all age groups. The only exception was among females aged 15-19 (4.5% vs. 3.8% existing at time of 1996 survey). However the general trend is encouraging. In fact, if the question had been phrased "...in the last 3 months" instead of percentage reporting two or more partners "currently" in 1996, the 1996 groups might have reported even higher numbers, making the 4-year differences even greater.

Incidence of Multiple Partnerships – 2000 compared with 1996				
Males	15-19	20-29	30-39	40-49
# and %	N=196	N=337	N=88	N=48
2 or More Partners	%	%	%	%
In last 12 months	56.1	56.7	43.2	22.9
In last 3 months	24.0	31.8	26.1	12.8
1996 (2 or > currently)	36.8	36.9	32.3	13.6
Mean # of Partners				
In last 12 months	2.80	3.54	2.68	1.39
In last 3 months	1.15	1.57	1.59	0.98
Females	15-19	20-29	30-39	40-49
# and %	N=132	N=306	N=113	N=44
2 or More Partners	%	%	%	%
In last 12 months	24.2	18.3	15.0	4.5
In last 3 months	4.5	5.2	7.1	2.3
1996 (2 or more currently)	3.8	7.0	9.3	6.8
Mean # of Partners				
In last 12 months	1.19	1.15	1.08	0.77
In last 3 months	0.90	0.83	0.89	0.68

From: *Highlights of the National KABP Survey on HIV/AIDS in Jamaica (First Draft)*

Efforts aimed at promoting single-partner relationships, and avoiding multiple partners, seem to be paying off in positive behavior change. Why the exception in females age 15-19, who are now more slightly likely to report multiple partners if they are sexually active at all? The KABP survey principal investigator and others in the NHCP believe this trend relates to national economic decline and associated increased poverty. Poverty may have encouraged multi-partnering among young females, since there is often a transactional element to sexual activity among women in this cohort. For example, many young women in this age group often report to CPEs, and during focus group discussions, that the "taxi man" is their sexual partner. Taxi drivers provide favors, gifts, cash and free rides to schoolgirls in exchange for sex, often picking them up soon after school.

If Jamaicans reduce their number of sexual partners, can this have a significant impact on HIV infection rates? Recent studies that have modeled the impact of different interventions on HIV infection rates in east Africa suggest that a reduction in the number of partners can have great impact on averting HIV infections, potentially greater than either condom use or treatment of STDs.

Delay of Sexual Debut

According to the 2000 KABP survey, the median and mean age of sexual debut rose from 13 to 14 for males between 1996 and 2000; it remained 14 for females. Earlier population-based, quantitative evidence (the 1997 reproductive health survey) showed that 50% of females aged 15-19 had had sexual experience, down from 59% in 1993. Therefore, the age of sexual debut seems to be rising overall since 1993, albeit slightly.

Delay of first sexual experience is promoted to youth, especially through school programs and by churches and other faith-based organizations (FBOs). FBOs insist that the NHCP's BCC program emphasize delay of sexual debut and abstinence. Some may question whether delay of sexual debut is a realistic BCC objective. In Jamaica, a recent qualitative study showed that some young people believed that 15 or 16 is the earliest that Jamaicans should begin to have intercourse. A focus group of "suburban" boys (from higher-income neighborhoods) believed that age 18-25 is "ideal" for first sexual experience. Yet sexual debut is at an earlier age. This means that there is a gap between beliefs, values and behavior. Strong promotion of delay of sexual debut ought to impact at least some young Jamaicans, especially if the message reaches them by age 10. In fact, the national KABP survey (2000) found a slight increase in the proportion of those surveyed who were not yet experienced sexually: an increase of a percentage point for males and four percentage points for females, as the following table shows.

Delay of Sexual Debut & Abstinence - 2000 Compared with 1996				
	Men		Women	
	1996	2000	1996	2000
Not experienced sexually	9%	10%	15%	19%
Abstinent	11%	9%	15%	8%

The survey also found that 19% of males and 27% of females are either delaying or abstaining, a not insignificant proportion of all Jamaicans surveyed (age 15-49). Thus the "delay" and abstinence messages seem to be worth continuing.

Recommendation: The "delay" and abstinence messages, promoted primarily through schools and churches, should continue to be part of the NHCP/BCC strategy. These messages should be targeted to children under age 15, and perhaps as young as 10.

It should be remembered that the emphasis of the project since 1996 has been on youth. Age-specific seroprevalence among antenatal clinic attendees show that the 15-19-year-old cohort had the lowest rates (.096%), although the next older group, ages 20-24, had the third highest rates (2.12%). These data are for women only. Seroprevalence among STI clinic attendees (male and female) was also lowest among those aged 15-19 (3.1%, compared to 7.1% overall).

2. SEXUALLY TRANSMITTED DISEASE CONTROL

The NHCP's output is to reduce STDs as a co-factor in the transmission of HIV infection to individuals at increased risk. The main components of the STD control program are:

1. STD case management;
2. Contact Investigator program;
3. Sentinel surveillance and reporting; and,
4. Quantitative and qualitative research to measure behavioral, biomedical and epidemiological outcomes.

STD Case Management

Syndromic management, first developed under the previous USAID-supported project, was originally developed on a pilot scale, then was scaled up to a national program. Only physicians can treat patients, though Jamaicans do go to pharmacies to seek STI treatment. Syndromic management, including historical screening to reduce the asymptomatic pool, and partner referral, is now the accepted national policy. STD treatment centers have been established in each of the 13 parishes, and health workers continue to receive training in syndromic management of STDs. With decentralization, regional and parish health authorities are now responsible for assessing the training needs of their health staff. Approximately 400 health workers were trained under the project in 1998/1999.

Prevalence of curable STDs (chlamydia, gonorrhea, trichomonas and syphilis) among symptomatic women attending STD clinics was 54% in 1994; 27 % among those attending family planning clinics in 1995; and 30% among those attending antenatal clinics in 1997. Among women, these conditions were often without symptoms, thus increasing the risks of transmission, including to their infants. This problem has been successfully overcome since the national program adopted an integrated approach to the management of STDs, especially among women. Though etiologic reporting of gonorrhea and chlamydia cases are now more reliably based on determined prevalence rates, no studies have been done since 1994.

Reported incidence of primary and secondary infectious syphilis (P&SS) decreased for the tenth consecutive year to 12 per 100,00 population in 1998. As a result, the original P&SS target of 13 set in 1996 for the end of project year 2001, has been revised to 8.5, with 9.0 for males and 7.5 for females.

Decreases were also recorded in reported cases of congenital syphilis, herpes, ophthalmia neonatorum, and other STIs, as the table below shows.

STI	1999		1998		1997	
	Cases	Rate	Cases	Rate	Cases	Rate
Syphilis, all stages	704	27.2	979	38.0	1,450	56.8
P&S syphilis**	270	10.5	321	12.4	359	14.1
Chancroid	204	7.9	239	9.3	283	11.1
Herpes	326	12.6	395	15.3	369	14.4
GUD, male	1,054	81.6	1,157	89.7	1,268	99.8
GUD, female	935	71.9	709	55.0	867	67.7
Urethral Discharge	6,992	541.1	9,506	736.9	15,171	1,857.1
Vaginal Discharge	15,978	1,230.7	17,746	1,375.7	38,942	1,525.0
Paediatric HIV/AIDS	70	12.6	55	9.0	44	7.3
Congenital syphilis*	17	28.8	25	42.5	30	52.3
Ophth. Neonatorum*	141	238.9	144	244.1	201	350.4
Clinic visits - Male	14,532		14,988		17,007	
Clinic visits - Female	27,858		27,223		27,218	
Total Clinic Visits	42,390		42,211		44,225	

From: National HIV/STI Control Programme Report 1999/200 & USAID/MOH Annual Report 1998/1999, NHCP

* CS and ON: rate per 100,000 live births / Paediatric HIV/AIDS per 100,000 ages 0-9 years

** Primary & Secondary (infectious) Syphilis

Factors contributing to STI decline include:

- Contact tracing and related in-country training (a training-of-trainers model is used, making program less expensive and more sustainable)
- Training in laboratory testing
- Syndromic management and local level treatment for STIs
- BCC, which is implemented by health educators and Contact Investigators

Contact Investigators

Jamaica is perhaps the only developing country where contact investigation has been an integral part of STI control services for over 50 years and is widely accepted by health providers and the public. Contact investigation has been credited by the medical profession as the biggest contributing factor in the decline of STI rates, and is assessed by local experts as an essential, cost-effective component of STI control. It is also an essential component of HIV mitigation and is often credited with stabilizing HIV infection rates.

The Contact Investigator (CI) is a trained health professional, largely recruited from other public health disciplines, such as registered and enrolled assistant nurses, health inspectors, and midwives. Except for three CIs who recently changed jobs, CIs are committed and tend to stay in their jobs. Salaries are comparable to that of nurses (J\$25,000 starting). Initially passive surveillance of gonorrhea and syphilis were used as indicators to guide the activities of the CIs. In 1998, HIV/AIDS was added, and the results of contact investigation were first reported in 1991. Active surveillance is carried out for congenital syphilis and for pediatric HIV/AIDS cases.

CIs do more than trace contacts of those infected with STIs or HIV. They also develop a relationship of trust with clients who test positive—a relationship that endures over time. They do pre- and post-test counseling and provide practical advice about treatment, finances, stigma, and jobs. Turnover among contact investigators is low and signals that the work is rewarding. In fact, there is much higher turnover at higher-level jobs related to HIV/AIDS.

In their BCC role, CIs go to factories, schools, churches, and other community-based groups to conduct HIV/AIDS education. A CI sees an estimated 75-100 people per week. CIs report the number of contacts monthly, but do not report the number of people reached in group activities/presentations. Only individual contacts are reported. Thus, the number of total population reached is actually much higher. All informants said that CI-CPE relations were good, and that CIs are hard-working and effective.

Some 39 CIs have been trained. There are 35 to 49 CPEs. The CI program was launched in the 1940s, when there were only 4 CIs tracing STI partners. The tracing of HIV partners was added in 1988. The current role of CIs includes the following:

- CIs trace contacts and advise the partner to be tested for HIV, gonorrhea, resistant gonorrhea, and chlamydia, and carry out pre-and post-test counseling (50% of their time allocation).
- CIs are community HIV/AIDS educators and promote condom use among high-risk groups (20% of time).
- CIs are community health educators for the general population (5%).
- CIs perform clinical work (10%).
- CIs assist with surveillance (5%).
- CIs perform data entry or recordkeeping (5%).

The team also learned that CIs often do long-term counseling and advising among persons living with HIV/AIDS (PLWHAs), which amounts to work in care and support. Strict adherence to essential components such as confidentiality, protecting the source of information, and discretion in tracing contacts has contributed to the success of the program.

Lesson Learned: In discussions with USAID/Washington staff, there was concern that contact tracing in Jamaica and elsewhere could be a potential violation of human rights, something that leads to exposure (or "outing") by the government and may result in reprisals or stigma. Yet, by all accounts, the program in Jamaica has worked well. CIs maintain trust and confidentiality, and they serve an important role and function in care and support, voluntary counseling and testing (VCT), HIV prevention, and in dealing with psychosocial issues. Other countries might do well to learn from the Jamaican experience in contact investigation.

Constraints

The loss of trained personnel from public facilities and the lack of a well-structured training system to attract physicians and other health professional from the private sector remains a continuing constraint. The last successful government-initiated training for private practitioners was implemented in 1994-1995 when 379 physicians and 249 nurses participated in STI seminars in Kingston, Montego Bay and Mandeville. The high attendance rates and self-reported STI management practices demonstrated that continuing medical education that targets the private sector can be successful, and should be included as a standard activity to improve care and provide a public-private link to STI/HIV control.

The Epidemiology Unit estimates that more than 60% of all STIs are managed within the private sector, where two-thirds of Jamaica's 1,300 registered physicians practice. A 1993 survey revealed a mean of 5.5 STIs were diagnosed per private practitioner per week.

Finally, the CI program is not without problems. The Acting Head of the CI program told the team that CIs are overworked, and that the program needs more staff and better supervision. Decentralization issues and uncertainties regarding central versus regional posts, appointment to the post of Chief Contact Investigator, and payment of salaries need to be addressed. In 1999, 35 of the total of 39 CI posts were filled.

Despite these problems, the CI remains a valuable resource for the development of STI/HIV program plans, especially in rural areas, and in the clinical management of patients with STI manifestations.

Recommendation: The Ministry of Health should expand its current training to include supervisors to relieve overburdened CIs from the informal role of overseeing the work of CPEs and volunteer PEs. At least one trained supervisor per region should be appointed.

Training of Private Physicians

Most physicians interviewed during this evaluation spoke about the increasing numbers of AIDS patients in need of care and bed treatment, now entering the hospitals and hospices. Their concerns range from lack of resources in the public hospitals to deal with the increase in patients to the reluctance of some health care providers to care for AIDS patients.

In 1994, under the first phase of the USAID/Government of Jamaica project, physicians were trained in syndromic management of STIs. About 390 private physicians attended workshops that were arranged by the AIDSCAP project, with the active support of the Medical Association of Jamaica. In the current phases of the project, private physicians have received *ad hoc* training in this area through the Ministry of Health. Some training in STIs was carried out in the western region of Jamaica during 1999, and training in drug detailing by Glaxo was carried out in the southwest region (Mandeville). Physician training was offered, but the criteria for selection at the last workshop in May 2000 was limited to physicians who had treated HIV/AIDS patients and who had sent in HIV reports at least once during the past five years.

Recent interviews with private physicians have revealed the following:

- There is a small group of physicians treating an increasing amount of HIV/AIDS patients.
- Physicians would participate in formal training, refresher training and continuing education programs organized by the Ministry of Health and/or Medical Association of Jamaica.
- Although many are members of the Medical Association of Jamaica, they are not regular participants in the monthly parish meetings or even in the Annual General Meeting.
- It is important to regain the support and skills of these physicians, who will continue to deal with the increase in HIV/AIDS patients.
- Many of these physicians graduated from the University of the West Indies and received quality training in STIs from that institution. However, HIV/AIDS is not part of the curriculum. The scope of the STI curriculum has in fact been reduced in the undergraduate program.

Recommendation: Private physicians should be encouraged and offered incentives to participate in well-designed and systematically presented training and orientation programs in syndromic management of STIs, voluntary counselling, testing and treatment of HIV and AIDS patients, drug detailing, and alternative therapies

Recommendation: HIV/AIDS prevention, treatment and care should be integrated in the undergraduate curriculum of the Faculty of Medicine at the University of the West Indies, and the current STI component strengthened to adhere to internationally approved standards.

Training of Health Care Workers

Since 1996, the NHCP's training components have been mainly targeted to health care workers - CIs, CPEs, nurses and physicians - in the public sector. Quarterly reports describe a series of workshops at the parish and regional level. At the parish level, the focus was on sexuality programs in schools, HIV/STI prevention, and sensitization. At the regional level, the focus was on pre- and post-test counselling, research and evaluation methods, and networking and team building.

Although the training was deliberately targeted at local and community-level health care workers, it prompted a more expanded outreach response. Training was fragmented and not designed as a systematic part of the project, however. The quality of training is difficult to assess because it was organized at many different levels with little or no built-in follow-up or evaluation mechanisms. Anecdotal reports from the public through the HIV/STD Helpline, as well as other sources, seem to indicate general improvement in the attitudes and practices of health care workers, though some are still reluctant to manage patients with HIV and/or AIDS.

Nutritional counselling at the Comprehensive Health Center in Jamaica is a success story that could serve as a model for the other regions. Strongly supported by the Kingston-St. Andrew Parish AIDS Committee's Nutrition Subcommittee, qualified nutritionists have functioned as counsellors in advising and caring for HIV and AIDS patients, using both standard nutritional approaches and combining them, when necessary, with alternative therapies and indigenous pharmacopias that are typically Jamaican. Since the startup in September 1997, more than 600 PLWHAs have been counselled. Because it has the potential to serve as a national center for expanded training of health care workers in counselling, it would be an opportune time to explore the capacity of the Comprehensive Health Center to take on this additional responsibility.

It would also be appropriate to conduct a qualitative assessment of the perceptions of the public and HIV/AIDS patients regarding how health care workers treat such patients and, if necessary, to conduct additional training for new staff and refresher training for staff trained in the early 1990s. Ongoing in-service training on total quality management should also become routine at the central, regional and parish levels for both public and private sector health care providers.

Recommendation: Health care providers should be encouraged and offered incentives to participate in well-designed and systematically presented training and orientation programs in syndromic management of STIs, and voluntary counselling, testing and referral of HIV clients.

Recommendation: To meet the increasing demands nurses and hospital staff should be oriented and trained in the care of HIV and AIDS patients.

HIV/AIDS Surveillance

HIV/AIDS Surveillance in Jamaica includes three main components:

1. Conducting HIV serosurveys among STI and antenatal clinic sentinel groups in the parishes of St. James, St. Catherine and Kingston-St. Andrew;
2. Monitoring of trends in HIV seroprevalence among groups whose test results are available for analysis; and,
3. Monitoring of AIDS cases annually.

Routine HIV testing among sentinel groups, and antenatal and STD clinic attendees have been implemented in the Parishes of Kingston-St. Andrew, St. Catherine and St. James since 1990. However, based on AIDS reporting, the parishes that rely on tourism as a major source of income have been targeted for sentinel HIV testing to document monitoring of trends in HIV seroprevalence. These parishes have begun HIV testing among hotel workers but have not yet made any plans to test "beach boys" and others who interact with tourists.

Surveillance is conducted through a network of private and public laboratories, government clinics and some reporting from private physicians. Although the network is strongest at the central level, there are indications of non-reporting, duplicate reporting, underreporting, and lack of cooperation from infected and affected persons, as well as from the elaborate system of health care providers that fits into the surveillance system. The weak link, which is more removed from the central level, includes rural communities and families, as well as medical personnel who may have little contact with the Ministry of Health due to their distant geographic location—away from the Regional Departments and/or a professional culture.

The important areas of surveillance are found within the Contact Investigation Syphilis and HIV/AIDS Interviewing and Clinical Data. Provisional data for 1999 revealed that 97% of primary and secondary syphilis patients were interviewed, for a case-to-contact ratio of 1.8. Seventy-five percent of locatable critical period contacts were examined, with an infection rate of 32%. This infection rate in contacts, when located, shows a decline from the 1998 infection rate of 54%. On the other hand, the decrease in positivity from 46% to 41% among HIV contacts is more difficult to interpret because it may indicate either early intervention or inefficient contact elicitation.

A review of reported data from just before the start of the current project phase to the present shows that an average of 68% of contacts of HIV cases have been investigated by CIs, but only 8% of contacts of AIDS cases. This could be explained by the fact that the majority of HIV cases are first discovered by CIs at clinics whereas clinical AIDS cases are seen by private physicians, or that many cases of AIDS reported to the central database as new may, in fact, have been seen previously by the CIs as HIV, but the change in status has not been reported to the central database.

The Ministry of Health has initiated an in-depth analysis of data at the parish/region and central levels in an effort to explain this phenomenon. Preliminary findings of the LOCAL and HATS data show that the ratio of all contacts named to HIV/AIDS are 2:0 and 2:2, respectively. Newly

positive HIV/AIDS contacts were 40% and 41%, respectively, but locatable contacts to HIV/AIDS cases examined and counseled were 40% and 61%, respectively. The latter variation may be partly due to problems in the analysis caused by malfunctions in the HATS database.

The National Public Health Laboratory (NPHL) and five private labs in Kingston, as well as a lab in the northwest (Montego Bay) region, report on confirmed HIV testing on a quarterly basis. According to a review done in 1996, private labs were the source of more than 50% of overall confirmed HIV results. Contact between the CIs and private labs remains elusive and therefore there is no recent data on the amount of HIV-positive results attributed to private labs. A greater number of HIV testing kits are available and are used by private physicians in their offices, as demonstrated by the increase in requests for NPHL approval of testing kits.

The HIV/AIDS surveillance system is driven by the Epidemiology Unit in the Ministry of Health, which sets targets for testing. Once the data are sent to the Unit, they are entered into the HATS database and analyzed by surveillance personnel. Further analysis and distribution is usually done by the Chief Medical Officer, the Senior Medical Officer/Epi and the STD Advisor. These analyses and reports are distributed on a quarterly basis and used for presentations at national, regional and international consultations and workshops.

Since there is no registration of private labs or private physicians with regard to HIV/AIDS reporting, and notification is not compulsory, there is the potential for non-reporting or incorrect reporting. Labs must, therefore, be registered or at least encouraged to follow standardized procedures in order to guarantee valid data. Within the public sector, there are monthly meetings and quarterly workshops to review the results of tests and surveillance data.

Jamaican HIV Seroprevalence Data

There are HIV serologic data from antenatal clinics, high-risk groups such as STI clinic attendees and CSWs, and groups from the general population (e.g., life insurance applicants, defense and constabulary forces, migrant farm workers, blood donors, US Visa applicants, and all those tested in private labs). Since 1999, particular groups have been being sero-tested because they are thought to be at higher risk for HIV infection: hotel workers, factory workers, family planning clients, targeted communities, and adolescents, for example.

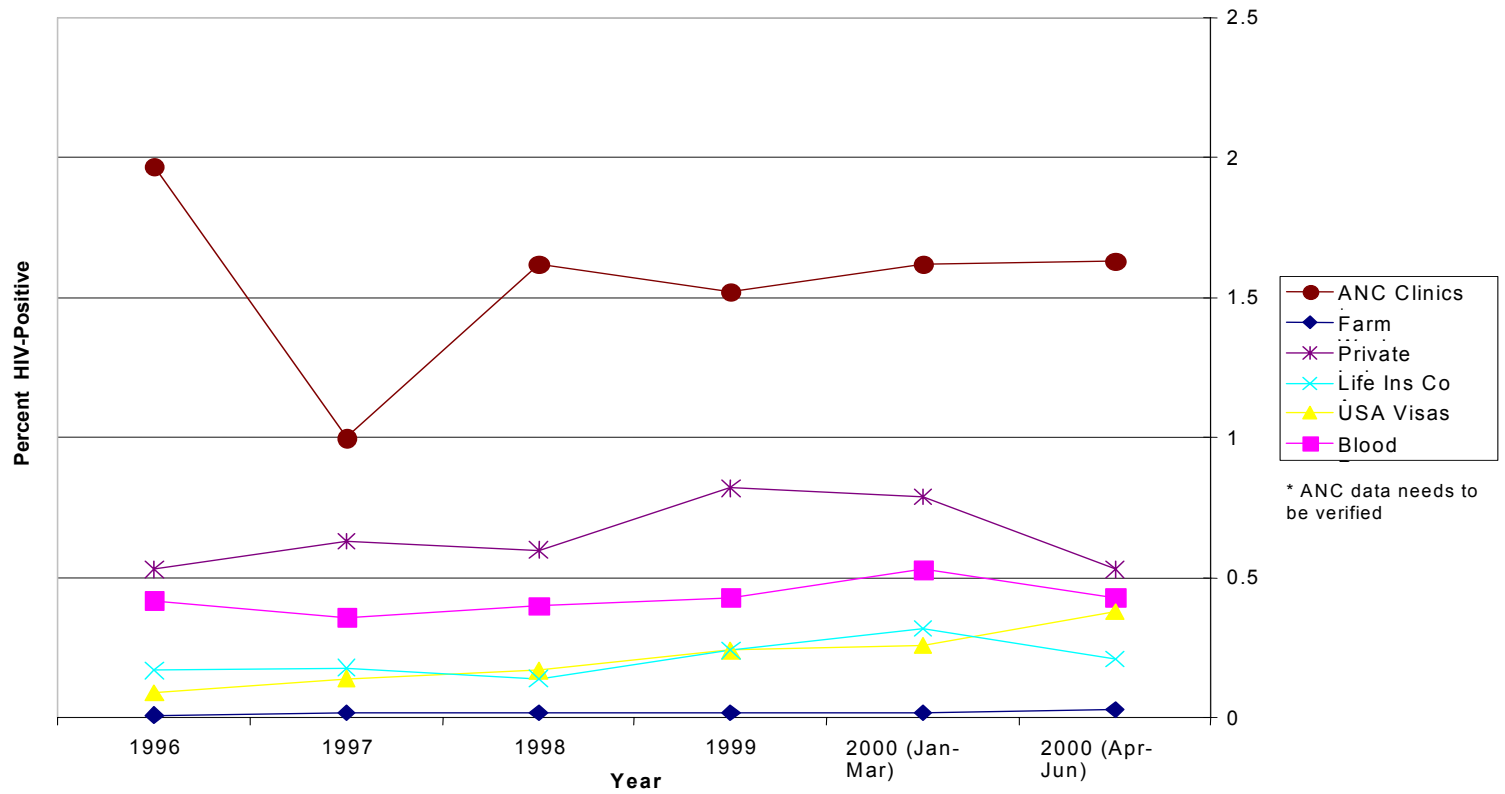
The following table summarizes HIV seroprevalence data from 1996 to 2000 among these selected groups.

HIV SEROPREVALENCE AMONG SELECTED GROUPS 1996 - 2000

	1996		1997		1998		1999		2000 (Jan-Mar)		2000 (Apr-Jun)	
	# tested	% +ve	# tested	% +ve	# tested	% +ve	# tested	% +ve	# tested	% +ve	# tested	% +ve
Farm Workers	10,215	0.01	10,481	0.01	11,220	0.02	13,305	0.02	5,639	0.02	6,944	0.03
Blood Donors	23,570	0.42	24,958	0.36	23,249	0.40	23,377	0.43	7,401	0.53	6,452	0.43
USA Visas	9,017	0.09	9,080	0.14	9,404	0.17	8,594	0.24	1,895	0.26	1,852	0.38
Life Ins Co Ass	11,062	0.17	9,422	0.18	7,827	0.14	7,036	0.24	2,771	0.32	2,996	0.21
JDF	--	--	1,035	0.19	206	0.48	--	--	517	0.77	132	0.76
JCF	--	--	503	0.00	386	0.00	--	--	116	0.00	100	0.00
Hotel Workers												
Private Labs	46,966	0.53	42,292	0.63	43,338	0.60	39,792	0.82	13,383	0.79	15,554	0.53
NPHL	15,5443	8.22	17,435	8.57	20,227	8.83	23,457	8.88	7,098	7.60	6,659	8.10
Adolescents												
ANC Clinics		1.96		0.98		1.50		1.60		1.60?		
AIDS Cases m/f	307 / 184		372 / 237		410 / 233		539 / 353		Total 2730 / 1704		Deaths 1672 / 995	

Sources: Seroprevalence data for 1996-1999 from Supplementary Report, HIV Prevalence Among Selected Groups, Division of Health Promotion & Protection/MOH
 Seroprevalence data for 2000 from Quarterly Report April- June 2000, National HIV/STD Prevention and Control Program/MOH
 ANC clinic data for 1996 from Medium-Term Plan 1997-2001, National HIV/STD Control Program/MOH
 ANC clinic data for 1997 from Annual Report 1997-98, National HIV/STD Prevention & Control Program, USAID/MOH
 ANC clinic data for 1999 from Annual Report 1998-99, National HIV/STD Prevention & Control Program, USAID/MOH

HIV Seroprevalence Among Selected Groups, 1996-2000
Jamaica AIDS/STD Prevention and Control Project



The NPHL is associated with the CDC in Atlanta, Georgia, which establishes and maintains quality control standards. In recent years, the NPHL has consistently received good quality ratings for sero-testing. However, it is interesting to note that variations persist between the data from ANC clinics as reported by the Ministry of Health and other "standard" international epidemiological reports periodically issued by the Joint United Nations Programme on HIV/AIDS (UNAIDS), PAHO, and the US Bureau of the Census, as summarized in the table and graph below.

HIV Prevalence & Incidence in Jamaica 1992 - 2000									
Variations in Estimates in National and International Reports									
	1992	1993	1994	1995	1996	1997	1998	1999	2000
MOH	0.45	0.21	0.60	0.55	1.98	0.98	1.50	1.60	1.60
UNAIDS	0.45		0.91			0.99		0.71	
PAHO*	0.42	0.90	1.37	2.07	1.97	2.42	2.53	2.62	
BuCen			0.90		2.0	1.0			

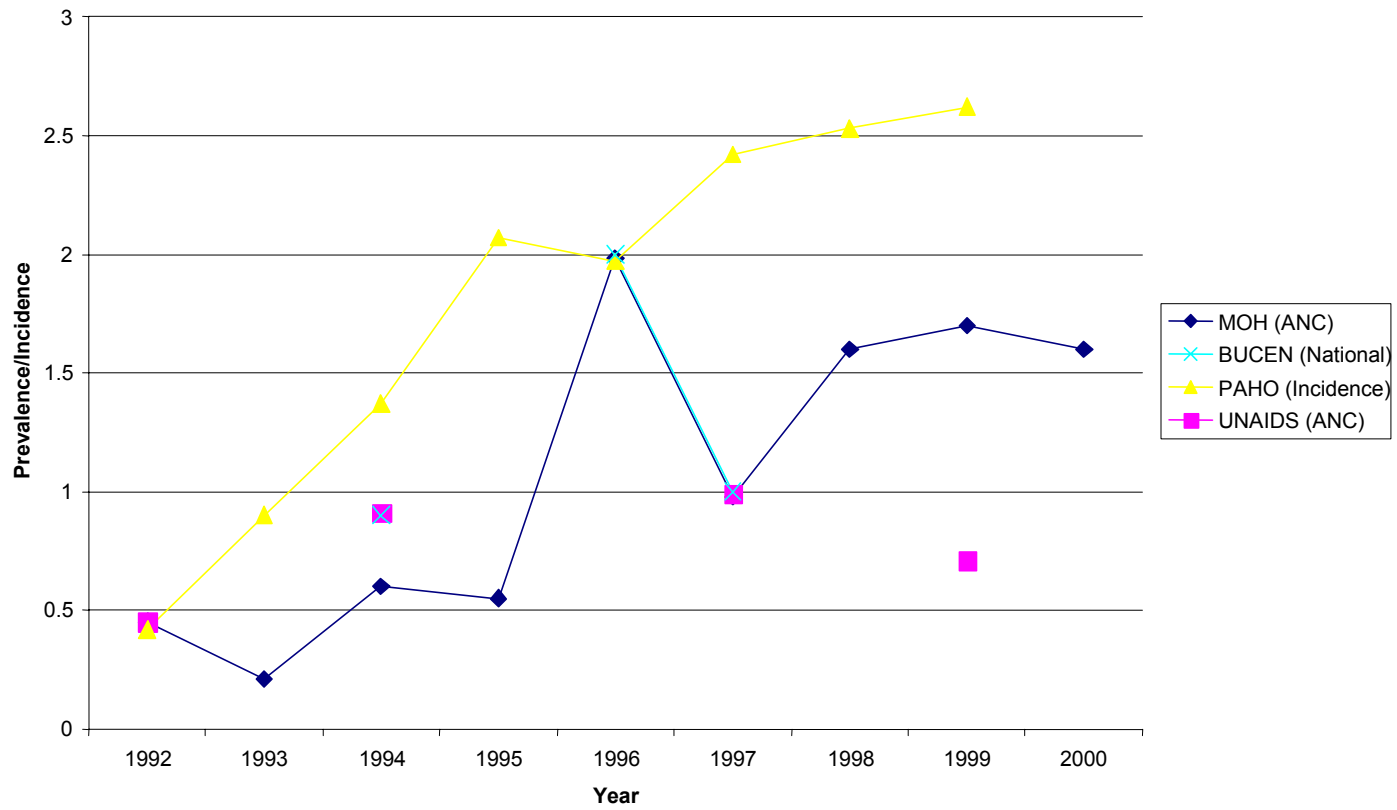
From: Epi Unit/MOH, *Annual, Quarterly & Supplementary Reports*, 1997/98, 1998/99 & 2000
 UNAIDS *Reports on the Global Epidemic*, 1993, 1995, 1998 & 2000
 PAHO *Bi-annual Reports on AIDS Surveillance in the Americas*, 1999 & 2000
 BuCen *HIV/AIDS Surveillance Database*, 1998 & 2000

***PAHO estimates are HIV Incidence – MOH, UNAIDS & Bucen are HIV Prevalence**

Sentinel surveillance was conducted between 1990 and 1998 in three parishes: Kingston-St. Andrews, St. Catherine and St. James. In 1999, surveillance was conducted in 7 additional parishes (but the original 3 parishes were said to still be used for comparative purposes). The new parishes in 1999 were: Hanover, Westmoreland, Trelawny, St. James, St. Anne, Clarendon, Manchester, and St. Thomas. In 2000, 10 parishes will be involved in sentinel surveillance, targeting a total of 6,835 antenatal and STD clinic attendees, CSW/Dancers, adolescents, hotel workers, and factory workers. Difficulty in obtaining reports from other agencies continues to affect the ability of the Ministry of Health to provide timely and complete reports on seroprevalence data.

In 1999, a total of 1,925 women were tested in 7 parishes in antenatal clinics. Almost 2 percent tested positive, making the antenatal clinic figure considerably higher than 10 or so other groups that to some extent represent the general population, and for whom there is comparable data. It is not entirely clear why this is so, but it has been suggested that there are various selection biases in each of the groups. In any case, it is usually data from antenatal clinics that are used for international comparisons and for trend analysis. During the current phase of USAID funding, the antenatal clinic seroprevalence rates have dropped from 1.9% to 1.6%, although the Epidemiological Unit staff feels that the relatively high figure in 1996 was not accurate due to problems of sample size in St. James that year.

HIV Prevalence & Incidence in Jamaica, 1992-2000



3. CONDOM SOCIAL MARKETING

The target for this intervention is a 20% increase in condom sales by the end-of-project. An island-wide network of at least 2,000 non-traditional retail outlets would be established in collaboration with the National Family Planning Board.

Condom social marketing (CSM) was a sub-component of one of the three project components—namely, condom promotion, the aim of which is to promote sustained condom use. The CSM program was the last sub-component to begin (1997) and the first one to end (September 1999). The Ministry of Health hired a marketer to design and implement CSM, but apparently she was provided no staff. The goal of the CSM program was to penetrate rural areas and increase condom availability in non-traditional outlets (e.g., small shops, bars, clubs, gas stations, hotels, and street vendors) through creative partnerships with the private sector. This effort was designed to complement the free (unbranded) condoms distributed in the public sector, mostly through health centers.

The CSM program collaborated with private sector condom companies and distributors to achieve broad distribution. The incentive for these commercial enterprises to work with the Ministry of Health was that the CSM program would expand markets and, therefore, sales. It would also directly develop point-of-sale materials (e.g., stickers, dispensers) and try to ensure that condoms were placed in the front of shops, in visible locations. The CSM program also set up wholesale distribution points in rural areas that were unused by major companies and distributors.

In addition to placing condoms in small shops and other non-traditional retail outlets, the CSM program identified and trained volunteer PEs as mobile salespersons of condoms. These PEs were given the first supply of condoms for free. With money from initial sales, PEs would then buy more condoms from wholesalers, at wholesale prices, sell condoms at the prevailing retail price for the area, and make a small profit on each sale.

The CSM program did not have the resources to conduct generic advertising of condoms via mass media. A separate contract was awarded to an advertising firm to do this. By all accounts, the funds for this activity were not well-spent, and there was little effective electronic media promotion of condoms, or use of such media in HIV/AIDS awareness promotion or education. The CSM program did become involved in local "bashments" (dance parties) and contests, during which it promoted condoms and their use, along with HIV/AIDS/STI print materials.

A condom availability (retail audit) study was conducted by HOPE Enterprises in December 1999. It shows that condoms were found in the "vast majority" of retail outlets, traditional and non-traditional (97-100% levels) in *towns*. Condoms were also affordable (using the World Health Organization formula of less than 2% of minimum wage for 100/year). The audit showed that "Slam" is the most widely distributed brand, found at 88% of all outlets. "Panther," the condom formally socially marketed under USAID's SOMARC project, was found in 49% of outlets. The former CSM manager feels "Slam's" success is due to: 1) advertising that features a well-known "Dance Hall Queen", Karlene; and use of an attractive, visible dispenser which hangs on walls at points-of-sale.

Sales data indicate that the overall condom market has grown from 5,764,160 units in 1991 to 10,814,664 in 1999, almost doubling. Using a different methodology, the Ministry of Health estimated that 13,869,187 condoms had been distributed or sold by 1999. The actual number may therefore be somewhere in between 10.8 million and 13.9 million. The private sector's share of the condom market has more than doubled in recent years, from 30% in 1992 to 67% in 1999 (Hope Enterprises, "Condom Availability, Affordability and Market Size Survey," 1999). In other words, subsidized condoms represent only 33% of the total condom market.

Since the NHCP's CSM program ended in 1999, condom social marketing continues, mostly through the sale of condoms by peer educators. Parishes buy condoms directly from wholesalers, then sell them at local retail prices, making a slight profit which serves as an incentive for PEs. In fact, condom profits are the only form of monetary compensation for volunteer PEs. Some regional health staff feel that a central procurement mechanism (above the parish level) is needed to allow the purchase of condoms in greater bulk and at lower prices, potentially increasing profit margins for PEs.

Is a national CSM program still needed? The Ministry of Health seems to feel that CSM is no longer needed at this time, noting that condoms are widely available at a variety of outlets. Some condoms are free and commercial ones are affordable at 25 cents (US), or 60 cents (J), per 3-pack.

However, the former CSM Manager feels that CSM (in 1999) was still not widely available in rural areas. The manager also felt that the CSM program was not well-understood or appreciated by the Ministry of Health, nor was it sufficiently integrated with other NHCP programs.

On the basis of preliminary KABP survey results, the survey's Principal Investigator felt that: (1) mass media promotion of condoms or HIV/AIDS education through radio or TV is lacking; (2) mass media awareness efforts should have continued after 1996; (3) emphasis on face-to-face BCC should not exclude continuation of mass media messages (the NHCP did continue such efforts, but only in September 2000, following the KABP survey); and (4) more and better use of mass media for BCC is needed.

The newly funded adolescent reproductive health project of USAID (awarded to The Futures Group) will support contraceptive social marketing as one of its components. Perhaps the NHCP should find a way to promote HIV/AIDS education through this existing resource.

4. STRENGTHENING OF EPIDEMIOLOGY UNIT

Project interventions focused on strengthening the management capability of the Epidemiology Unit in order to make maximum use of donor assistance and enhance the efficiency and effectiveness of its operations. Capacity building focused on management training, team building and change management.

The integrated management and services approach in the Epidemiology Unit has continued to build on its successful experience under the original project agreement, emphasizing policy decisions and providing technical guidance for BBC and social marketing, as it has done for STI prevention. It has evolved into the administrative and technical center of the NHCP, with the

ability to assume greater responsibility for implementing the NHCP, including the USAID-funded components.

As decentralization proceeds to take root, the Epidemiology Unit has steadily disengaged itself from the day-to-day responsibilities for either the regional or parish operations. The Regional Senior Medical Officer is administratively responsible for the BCC regional office and the Parish Ministry of Health is administratively responsible for the CPEs. The Epidemiology Unit remains responsible for BCC operational policies, training, materials production, evaluation and special support for the CPEs.

Weaknesses still exist regarding the strengthening of research capabilities and development of monitoring and evaluation mechanisms. As a result, there have been delays in carrying out or contracting for quantitative and qualitative research and evaluation activities, including behavioral, epidemiological, biological and social outcomes. The focus has remained on the STI service and reporting component.

The Epidemiology Unit is now part of the larger Health Promotion and Protection Division, which is headed by the Principal Medical Officer, effective November 1999. This Division consists of the HIV Prevention and Control, Health Promotion and Education, Epidemiological Research and Analysis, and Environmental Health and Nutrition programs. The Prevention and Control of HIV and STIs Program, which is linked horizontally with the other units, is directed by the Senior Medical Officer (SMO). The Epidemiology Unit now relates directly to standards and norms, and policy regarding HIV/AIDS and STIs. The SMO also works directly with the Regional Technical Directors in the four regions and with the Parish Medical Officer of Health. Although surveillance is now a separate section, the SMO is technically responsible for the analysis, synthesis and dissemination of the data on HIV/AIDS, both to the public and to Health Departments. This dissemination comprises quarterly reports, presentations at workshops, and repackaging education messages for the mass media.

5. STRENGTHENING OF THE NATIONAL AIDS COMMITTEE

The NAC, established in 1988 as a registered private voluntary organization under the WHO Global Programme on AIDS, has experienced challenges in addressing critical issues that confront the nation with regard to HIV/AIDS policy and advocacy. Much of its efforts have been centered around reaching stakeholders and responding to their wide-ranging priorities. In the past year, serious attention has been given to rethinking and planning the mission goal and priorities of the NAC, taking into consideration the context of the epidemic in Jamaica.

While initiatives have sought to bring PACs within the organizational structure of the NAC, the PACs continue to maintain their individuality as separate organizations. At a workshop held in 1999, sustainable long-term strategies for NAC/PAC collaboration were explored in the areas of policy, legislation, programming, reporting and funding. These have yet to be implemented and monthly reports from PACs have not been consistent, thereby making it difficult to report regularly about committee activities.

The NAC remains the best vehicle for carrying out policy and advocacy functions. It does so by bringing together the key stakeholders in the public and private sectors to help implement and monitor the NHCP Medium-Term and Strategic Plans, which place great emphasis on a multisectoral response to the epidemic. Though most persons interviewed commented favorably on the “excellent” concept of the NAC, especially in bringing together the public and private sectors, they were also quick to point out that it had been plagued by problems in the areas of public perception/image, executive leadership, and lack of resources. At the central, regional, parish and NGO levels, the common view was that the failure to consolidate the NAC's role as advocate and monitor could be attributed to several factors, including the lack of clearly defined infrastructure, weak political commitment, poor mix or balance of active volunteers, failure to use PACs as key players on the Executive Committee, the need for greater stature for the position of National Coordinator, and inability to link to organizations outside the Ministry of Health.

Because the NAC was established by the Ministry of Health as a prerequisite for WHO funding in 1988/89 and was originally considered a Ministry responsibility and function, Committee development has been erratic. Currently, the NAC is comprised of 75 private and public sector organizations that make up five committees chaired by professionals such as lawyers, physicians, epidemiologists, psychologists and educators.

The NAC has two USAID-funded staff positions: the National Coordinator and the Secretary. They are physically located in the Epidemiology Unit at the Ministry of Health. This means there is good and regular interaction with key NHCP staff, such as the HIV/AIDS and STI Director, the BCC Coordinator and STD Advisor, as well as other donor representatives who work on HIV/AIDS projects. It also means the NAC is seen as a part of the Ministry of Health.

National AIDS Committee and Parish AIDS Committees

The NAC serves as an NGO whose purpose is to provide leadership and serve as a forum for setting the standards for coordinated government agency (i.e., health, education, local affairs) and multisectoral (i.e., trade unions, insurance and banking, chambers of commerce, NGOs, churches and other faith-based organizations, hotel and tourism industries) responses to HIV/AIDS prevention, care, treatment and support. The PACs are an integral part of the response to this national process.

Through both membership on the Executive Committee and subcommittees (Technical, Legal and Ethical, Counselling and Social Support, Education, Fundraising) of the NAC, the PACs can play a strong and active role. To date, however, only a few of the PACs have taken advantage of this unique opportunity to influence the national effort. Extremely active PACs such as those in Portland, St. James, St. Anne, St. Catherine, Clarendon, Hanover, and Kingston-St. Andrew, are characterized by effective leadership, a broad base of representation, and a high level of community involvement. Issues of stigma and homophobia associated with HIV/AIDS were reported as reasons hindering volunteering on PACs. Those working in rural areas suggested to this evaluation team that it would be better to have a Parish Health Committee, rather than an explicitly named AIDS Committee. In Manchester, where there is little urgency to get the PAC up and running

because HIV prevalence is low, a Parish Mental Health Committee was recently established and has successfully attracted volunteers.

Recommendation: Leadership of the NAC should be classified and funded at a more senior level, with the Executive Committee being more inclusive of PAC leadership and playing a more supportive role in regular operations at the national level

Recommendation: Since the NAC *Workplan 2000-2001* objectives are similar to those of the UNAIDS Theme Group's *Integrated Plan of Action 2002-2001*, better collaboration between the two groups would increase the cost effectiveness of some activities that overlap, and would greatly reduce the level of “committee fatigue” for those who regularly attend meetings of several different committees on the same subject.

Recommendation: Guidelines for workplan and budget development should be developed to ensure that regional priorities reflect parish and local needs.

6. REGIONALIZATION AND PARISH AIDS COMMITTEES

The health sector reform process in the Ministry of Health mandates a significant emphasis on a decentralized management policy. Four regions, in addition to Kingston-St. Andrew, were established, with four Regional Coordinators stationed in the regional offices. It is expected that the Regional Coordinators will be included in the Ministry of Health system when USAID assistance (under the 1996 amendment) ends in 2001. Their responsibilities include management or coordination of interventions, delivery of services under the new BCC strategy, and participation in NHCP outreach activities. In addition, they recruit, supervise and arrange for the training of CPEs.

Parish AIDS Committees represent a different “decentralized” response to HIV/AIDS/STIs, working as task forces at the parish level in coordination with the NAC. PACs are now located in all 14 parishes. Each parish committee is registered as a nonprofit humanitarian NGO, with a focus similar to that of the NAC, and is comprised of public and private sector groups, and members of NGOs, CBOs, youth clubs and other community groups. Programs emphasize prevention strategies, education, support, advocacy (human rights of PLWHAs), and generation of national and international affiliations. The PACs' primary focus is on sensitization of issues related to HIV/AIDS and STIs in schools, youth clubs and churches, and on implementing a support system for PLWHAs.

The most active PACs are in Portland, St. James, St. Anne, St. Catherine, Clarendon, Hanover, and Kingston-St. Andrew. Long lifespans and committed individual and community leaders are the main factors contributing to the success of PACs. They have been supported in some cases by both the private and public sector, with contributions in cash and kind. Notable among the fundraising efforts are those in Portland and St Anne; both are tourist-oriented parishes with concerned business leaders who have been actively involved.

The Portland PAC has been particularly proactive with youth groups, and has integrated itself not only into the local community groups, but also within the network of CIs, CPEs, physicians and others in the health care sector. It has an effective communication unit that uses desktop publishing software to produce newsletters, brochures and other materials.

The Kingston-St. Andrew PAC has been a leader in the areas of care and counselling, nutrition, and research, and has launched initiatives that may be replicable in other urban parishes. There is an interest in, and a potential for, the establishment of a Documentation Center that could serve as the repository and clearinghouse for the PAC system nationwide.

Although there is a relationship with the NAC, due to the vacancy of the National Coordinator, some of the PACs have become more independent and creative in responding to new areas such as care and counselling, especially in the encouragement of home-based and community care (Manchester). There is even some tentative interest in using local holistic remedies to alleviate the pain and suffering of AIDS patients who have little access to care.

The comparative successes of the PACs in comparison to the NAC are probably attributable to the spirit of volunteerism in local communities—a legacy of the colonial and religious history of Jamaica. Since the 19th century, volunteering has been an important part of civic and village life, especially among church workers, social development workers and health workers, who consider it prestigious.

7. NONGOVERNMENTAL ORGANIZATIONS

NGOs, including churches and civic organizations, have been engaged in HIV and STI prevention, care and support programs for most of the history of Jamaica's response to the AIDS epidemic. Making the most of their access to individuals and communities at greatest risk, NGOs continue to be critical players in carrying out interventions. In some instances, NGOs also have influence over key decisionmakers and local leaders, through their constituencies.

The evaluation team visited several NGOs, including Jamaica Red Cross, Jamaica AIDS Support, Jamaica Network of Seropositives, and Mustard Seed, and learned about the activities of Our Lords Place, Food for the Poor, Dare to Care and the Centre for HIV/AIDS Research at the University of the West Indies. The team leader joined the strategic planning team for the USAID Caribbean Regional Initiative on a visit to the Ashe Caribbean Performing Foundation, where the team saw a special performance of *Preparing for the VIBES in the World of Sexuality*.

While NGOs have played an active role in HIV and AIDS awareness and advocacy issues and in services and training, considerably more attention needs to be focused on ensuring that technical and financial resources are readily available for their strengthened role in the national response, especially surrounding multisectoral programs. NGOs can be strengthened through two approaches:

1. Strengthen the NAC to serve as the "umbrella NGO" which, in consultation with the PACs, would coordinate the technical and financial resource inputs and monitor program outputs at the parish level.

2. Strengthen an existing NGO to serve as the "linking NGO," which, in consultation with the PACs and NAC, would coordinate the technical and financial resource inputs, provide training and technical support, and otherwise assist the linked NGOs.

Perhaps a combination of both approaches would be optimal, if there are sufficient resources.

Regarding the second option, there is only one international NGO currently working in HIV/AIDS: the Jamaica Red Cross. It is headed by a dynamic and experienced person committed to HIV/AIDS mitigation. There are several successful programs in care and counseling, and in prevention. Moreover, it has trained staff with administrative and technical experience, access to resources and links with international and national groups, and fundraising capabilities. It already works with many of the Jamaican NGOs and CBOs involved in HIV/AIDS prevention, care, training and support activities, and the majority of the NGOs and CBOs interviewed expressed the view that the Red Cross would make a good linking organization.

Each NGO cited in this report is involved in formal and informal collaboration. Apart from the reciprocity gained through collaboration, key persons in these NGOs serve as board and committee members for other NGOs, therefore making the process participatory and inclusive.

Lack of sufficient resources is a barrier to achieving collaborative goals, but the willingness to participate in a humanitarian effort brings relevance to these collaborative strategies. Such organizational sharing makes it easy for each NGO to be aware of the needs of others. It is a humanitarian act on the part of AIDS service NGOs to care for PLWHAs; there are no existing laws that address the rights of PLWHAs to receive care and treatment.

Listed below are pertinent details about NGO activities in care, counselling, treatment, prevention, training and advocacy:

- **Jamaica Red Cross (JRC)** at first provided *ad hoc* shelters for PLWHAs, providing housing and food. It later supported peer education with AIDSCAP funds, and launched care and counselling support services with Norwegian Agency for International Development (NORAD) funds. In addition to a youth-oriented radio drama series, *SAFE*, a youth-oriented radio station, JRC supports training and capacity building in other CBOs. Its peer education project is well developed and has been adapted by other NGOs, using a JRC manual on Life Skills initiatives. The director is an active member of the NAC and serves as the chair of the Education Subcommittee.

The JRC has donor-supported programs in reproductive health, which incorporate HIV/AIDS and focus on inner city communities. Their *Uplifting Adolescents Project*, supported by Development Associates with USAID funding, targets school dropouts, ages 10 to 14 years, to improve their literary skills and reproductive health. At present, the JRC operates four centers, which average 40 participants each.

One of the most recognized and respected NGOs in Jamaica, the JRC, which has played a strong leadership and advocacy role, has great potential for an expanded role in the future,

both in strengthening immediate NGO responses to prevention, counselling and training, and in long-term national responses to care, treatment and support.

- **Jamaica AIDS Support (JAS)** emphasizes providing support and care to those infected with and affected by HIV/AIDS, and provides support and education to members of specific high-risk groups (i.e., MSMs, CSWs, "Beach Boys," inner-city youth). It operates two hospices, one in Kingston, *Life*, which recently suffered major financial setbacks when funding (80% of the total, J\$ 35.9 million over 3 years) from the Government of the Netherlands was discontinued, and one in Montego Bay. *Life* had assisted more than 400 residential and day patients since 1991, a majority of whom were initially referred from other NGOs. Through a Home-Based Care Program, which provides home visits to give hands-on assistance with nursing care and counsel, they encourage family members and friends to care for their loved ones at home.

As is the case with many NGOs, JAS has independently or jointly trained volunteer PEs. Based on a recently completed evaluation funded by Christian Aid, JAS is about to embark on a training program with support from the Jamaica Social Investment Fund and the World Bank. More than 3,000 persons are expected to benefit from the program each year, while indirect beneficiaries – through workshops in the private sector, media appearances and sensitization workshops – will total more than 10,000 persons annually.

- **Jamaica Network of Seropositives (JN+)**, formed in October 1996, seeks to ensure that "HIV-positive persons not only play an active role and have a say in all that affects them, but also highlight their strengths, downplaying the image of them as the problem but rather, as a part of the solution." The group is actively involved in training volunteer PEs and self-help facilitators who work with PLWHAs in six Self Support Groups in Kingston-St. Andrew, St. Mary, Westmoreland, St. Catherine, Portland and St. James. JN+ has four priority areas: self care and treatment; support groups; public awareness; and income generation. Seropositive persons represent JN+ in the Caribbean Region Network of Seropositives, UNAIDS Theme Group (Jamaica), the National HIV/STI Technical Team, NAC, Advisory Board of the Jamaica Red Cross, and Executive Committees of six PACs.
- **Mustard Seed** is affiliated with the Roman Catholic Church and is located in Spanish Town. **Dare to Care**, a part of the Mustard Seed Community, has just been opened to house and care for children who are living with HIV/AIDS and are under the care of the Social Services Department. The first 14 children, all HIV-positive, came from various children's homes and were cases supervised by the Government Children's Services Division. The Government will be placing most of the infants and children, from ages 1 month to 7 years, if they are HIV-positive and without family or foster care.

Other NGOs that have been active in HIV/AIDS-related care and support activities include the following:

- **Our Lords Place** is a hospice for the terminally ill, operated by Brothers of the Poor in downtown Kingston. They have reported caring for about 100 terminal AIDS patients each month. Fundraising is done through the Roman Catholic Church in Jamaica and churches overseas.
- **Food for the Poor Clinic** supplies food and medication to other NGOs and has a limited capacity to do research and oversee patients treated in their clinic. Clients of other NGOs are often referred to Food for the Poor for medication, food, clothes and sometimes shelter.
- **Centre for HIV/AIDS Research (CHARES)**, at the University of the West Indies, takes in NGO clients who need hospitalization. From time to time, CHARES receives donations in medications and nutritional supplements, which it in turn shares with NGOs for distribution to PLWHAs.

Involvement of Religious Leaders and Organizations

The BCC component of the national AIDS program has targeted church organizations and congregations for some time. Moreover, there are a considerable number of clergy involved in the NAC and its subcommittees, and in PACs and their subcommittees, sometimes as chairpersons. Churches and FBOs have been especially interested in promoting fidelity (which can result in reduction in number of non-regular partners, if not in monogamy) and abstinence, which can result in delay in the age of first sexual experience.

Has promotion of fidelity and abstinence resulted in behavioral change? We cannot at this stage sort out causal factors, but the recent national population-based KAPB survey of Jamaicans ages 15-49 shows that there has been a significant reduction in the proportion reporting 2 or more sexual partners in the past 12 months, and a slight increase in the median age of sexual debut, both compared with the 1996 findings conducted by the same group. Evidence from a recent qualitative study showed that boys who delayed first intercourse were "raised in a Christian home," suggesting the influence of religion in delay of sexual debut.

CPEs interviewed by the evaluation team reported that "mainstream" churches have been cooperative of their AIDS education efforts, namely the Roman Catholics, Anglicans, Methodists, Baptists and Seventh Day Adventists. With some churches, there was resistance at first. But it only took pointing out that members of a particular church were infected to change these attitudes. The result is that Jamaica has had good, supportive relations between FBOs and national AIDS efforts, in both the public and private sector. The evaluation team was unable to find direct evidence of any clergy or religious organizations opposing the work of the NHCP. There were occasional allegations that Fundamentalist or Pentecostal churches criticized the promotion of condoms, but no real local evidence of this emerged anywhere. On the contrary, individual clergy and FBOs were cited virtually everywhere as helpful in not only providing care and support for PLWHAs, but also in supporting AIDS prevention efforts. Even the former manager of the government's condom social marketing program was able to promote condoms among church groups on several occasions, and

she found no church opposition to her efforts. However, as elsewhere, Jamaican FBOs have preferred to promote fidelity and abstinence rather than condom use.

A small survey was conducted in greater Kingston in June 1999 to assess the level of participation of churches in HIV/AIDS prevention in Jamaica. This survey was administered during Ministry of Health sessions with church groups in Kingston. Ministry of Health participants stated that counselling would be the most appropriate service for FBOs to provide.

Findings from the limited survey in July 1999:

Churches with HIV/AIDS ministry or special service for HIV/AIDS:	9.5%
Religious leaders who participated on HIV/AIDS program:	19.5%
Future plans to participate in HIV/AIDS prevention:	98%

Type of service provided:		Type of service to be provided in their plans:	
• Counselling	33%	* Counselling	19.5%
• Support	50%	* Support	14.3%
• Hospice care	0.0%	* Care	9.5%
• Education	50%	* Education	33%
• Fundraising	0.0%	* Advocacy	9.5%

Jamaica's experience in church-AIDS prevention relations has been unusual among developing countries. Jamaica shows parallels in this regard with other countries, such as Uganda and Senegal, that have had national-level success in stabilizing, or in significantly reducing, HIV seroprevalence. Jamaica's experience with FBOs deserves to be further studied for the lessons learned and best practices it has produced.

8. MONITORING AND EVALUATION

Though the 1996 Project Paper stated that prior to the beginning of the amended activities, a “full evaluation plan for the project and its individual results/outputs will be designed,” a plan was not designed and no specific requirements were agreed upon for management procedures for use by USAID/Jamaica to “ensure project adherence to agreed operations.”

In the absence of a formally agreed upon evaluation plan, much emphasis was placed on the quarterly progress and annual reports, which were qualitative in their focus, except for the surveillance and condom sales data and data on CPE and CI training. Internal monitoring at USAID/Jamaica thus relied on the timeliness, rather than the substance, of the required reports from the Epidemiology Unit. It was not until 1999 that national level BSS, KAPB or CSM surveys were commissioned and funded by USAID and the Epidemiology Unit for use in results review and assessment of progress toward accomplishment of project goals. **This draft report presents the findings from the preliminary drafts of these long awaited national surveys.**

Internal management of the project by the Epidemiology Unit, the Ministry of Health, the SO3 Team and USAID lacked a systematic approach to monitoring and evaluation. Overall monitoring by USAID/Jamaica was limited to review of annual reports and attendance at monthly meetings. The Epidemiology Unit relied largely on quarterly surveillance reports and condom retail sales estimates, without benefit of any systematic analyses, except for an occasional presentation by the Principal Medical Officer and Senior STD Technical Advisor at regional and international meetings.

Strengthened data collection focused primarily on epidemiological surveillance methods, both active and passive, to provide information on the magnitude and trends of STIs. An HIV/AIDS tracking system, referred to as the HATS Database, was developed with technical assistance from CDC and the US Department of Health and Human Services. While feedback was possible through electronic linkages with Parish level and laboratory staff, data quality was not systematically monitored and even the latest NHCP Annual Report (1998-99) states that the HATS computer database has been revised, but relevant staff need to be trained to use it. It adds the disclaimer, "The data provided is preliminary, and cannot be used to compare previous data."

Jamaica has committed to a comprehensive HIV/AIDS/STI prevention and control program, with monitoring and evaluation considered an integral and essential part of all program components, at both the national and parish levels. The NHCP Medium-Term Plan, 1997-2001, specifies the development and application of evaluation tools to guide policy, planning and development of the national response to HIV/AIDS. In addition to adopting the UNAIDS/WHO indicators for monitoring and evaluation, it also specifies the training Epidemiology Unit and parish staff in evaluation.

The NHCP Annual Report (1998-1999) states that the training to increase research and evaluation capabilities "remains to be addressed." A year earlier, the Annual Report stated that training to increase research and evaluation capabilities would be addressed by CDC, with corrections to the HATS Database, and staff training and written manuals of operations "to be addressed/completed in 1998/99."

Program weaknesses include a great dependence on donor agencies for some monitoring and evaluation components of the national program. Another limitation is the urban bias of HIV sentinel surveillance and the limited number of test sites, thereby precluding a true representation of HIV prevalence in STI and antenatal clinics across the country. The lack of detailed qualitative surveys to examine in depth the gap between knowledge and practice as it relates to condom use in females is also a weakness and needs to be addressed. The lack of legislation or updated guidelines relating to the management, care and human rights of PLWHAs and how they relate to others is another limitation, at the different levels of strategic planning and design, and monitoring and evaluation.

Recommendation: Strengthen the data collection and reporting systems through training of technical staff in the different components of the Epidemiology Unit and corresponding units in Regional Health Offices.

Recommendation: Develop and implement annual workplans for monitoring and evaluation, to include training and technical assistance in the Epidemiology Unit and Regional Health Offices, technical coordination of external contracts for data collection and analysis, and technical collaboration on internal data collection, reporting and analysis.

Recommendation: Establish a formal monitoring and evaluation unit, with a senior-level post to coordinate internal and external data collection and analysis, BSS, KAPB, and other quantitative and qualitative surveys and special studies, and to provide ongoing technical assistance and training to the other Epidemiology Unit components and Regional Health Offices.

Recommendation: Training manuals for the training of different categories of participants should be developed and standardized for use in the regional training workshops in research and evaluation methods.

III. FUTURE DIRECTIONS

The institutional strengthening of the Epidemiological Unit has resulted in significant progress in the implementation and monitoring of planned project activities. Yet, as this final evaluation activity revealed, considerable gaps still exist in technical and administrative areas, both with regard to this amended project and the overall national HIV/AIDS prevention and control program.

Further **strengthening of the capacity of the reconfigured Epidemiology Unit** is necessary, if the Unit is to continue as the focal point for technical coordination in the implementation of the current, and next NHCP Medium-Term Plan, especially because its structure has been changed under the reorganization of the Ministry of Health.

Institutionalization of training in STI syndromic management, clinical skills, counselling and support services, accessible initially to Jamaicans both in the public and private sectors, and eventually to others in the Caribbean, is an area that should be jointly addressed by the Government of Jamaica and the international and bilateral donor agencies that will be investing in the next phase of national HIV/STI prevention and control, and AIDS care, treatment and support programs.

Though monitoring and evaluation of program components and achievements have always been a priority of the national program, there are weaknesses in its systematic application at the central level, and it remains highly fragmented at the regional and parish levels. **Institutional strengthening of monitoring and evaluation** will require the development or adaptation of tools and methods to guide both policy planning and development and program management and implementation. Evaluation components should be a requirement in all activities carried out at the national, regional and parish levels. Training of staff in the reconfigured Epidemiology Unit should be expanded, with further development of the capacity for training of central, regional and parish staff, and establishment of mechanisms for collaboration with academic and research institutions for the design and conduct of special studies, surveys and evaluations.

While the Ministry of Health has assumed control of most of the technical positions, compromises have been made at the regional level due to funding constraints. This poses a danger of creating heavier workloads for those in posts formerly funded by USAID. With the growing burden of HIV/AIDS, this increase in both administrative and technical duties could lead to a decrease in the quality of performance, especially of the BCC Coordinators, including the supervision of CPEs and/or CIs. This in turn would directly affect the performance of the CPEs and CIs, adding to the problems posed by staff turnover.

The partnership for **technical collaboration between the Epidemiology Unit and the Regional Health Offices** that was initiated in 1997 needs to be further developed, if this partnership is to serve as a facilitator in consolidating the ongoing efforts under the health sector reform process to create technically and administratively strengthened and financially sustainable Parish Health Departments. Setbacks and delays blamed on the slowness of the decentralization process can, in part, be attributed to the fact that the Government of Jamaica continues to be burdened by high

debt and debt service (over 60% of the budget}, high interest rates, capital flight and a large fiscal deficit (7.7% of Gross Domestic Product). All of these factors have severely constrained public sector investment in social services and infrastructure.

Despite these constraints, there is room for optimism regarding further progress that can be made in the continued fight against the epidemic. Key leadership and partnership roles can be played by a strengthened and active NAC and a **strengthened an expanded NGO network**. A strengthened and independent NAC could take the lead in policy and advocacy, and mobilize active participation of the private sector and greater involvement of other government ministries. A strengthened and expanded NGO network could set the standard for public-private partnerships at the parish and community levels.

In its most recent strategy review in June 2000, the National HIV/STD Prevention and Control Program recommended a **greater focus on adolescent reproductive health**, to coincide with USAID's strategic focus in this area. Participants in this review included several frontline players, including Health Educators, CPEs, CIs, and NGOs such as JAS, JN+, JRC, CHARES, and other nongovernmental and governmental organizations, such as the Bureau of Women's Affairs, Children First, and YMCA. More attention should be given to **increased participation** by these and other frontline players such as physicians, nurses and other health care providers, and private and public sector organizations and agencies, in the planning and funding of expanded activities currently under the purview of the Ministry of Health and/or Regional Health Offices.

APPENDICES

A: LIST OF CONTACTS

B: SCHEDULE OF VISITS

C: DOCUMENTS REVIEWED

D: STATEMENT OF WORK

APPENDIX A
LIST OF CONTACTS

LIST OF CONTACTS

Ministry of Health

Hon. John Junor, Minister
George Briggs, Permanent Secretary
Peter Figueroa, Chief Medical Officer

Division of Health Promotion & Protection (former Epidemiology Unit / MOH)

Deanna Ashley, Director
Yitades Gebre, Director, National HIV/AIDS/STI Program
Alfred Brathwaite, Senior STD Technical Advisor
Valerie Marshall, National HIV/AIDS Program Administrator
Althea Bailey, National BCC Program Manager
Paul Gordon, Acting Chief Contact Investigator
Evadne Williams, Director, National Public Health Laboratory
Janet Neil, National Public Health Laboratory
Collette Myrie, Surveillance Officer

National AIDS Committee

Howard Hamilton, Chairman
Lystra Sharpe, Former Coordinator 1999

Kingston-St. Andrews Parish AIDS Committee

Rev. Patrick Cunningham, Chairperson
Sharon Dawson, Financial Subcommittee
Steve Robinson, Research Subcommittee

Portland Parish AIDS Committee

Dorothy Blake, Chairperson
Kerril McKay, Education Subcommittee
Shellene Powell, Fundraising Subcommittee
Samara Walker, Fundraising Subcommittee
Keisha McFarlane, Fundraising Subcommittee
Kerril McKay, President, Youth Group & Education Subcommittee
Kirk Williams, Treasurer, Youth Group
Catherine Ellis, Secretary, Youth Group
Teresa Holmes, Assistant Secretary, Youth Group
Shireen Aga, Resource Mobilization
Jean McLean-Campbell, RN/Midwife, West Port Branch Chairperson
Nancy Gissiawan, Buff Bay Branch Chairperson
Carol Wilmot, West Portland Branch Chairperson
Vincent Lowe, CI, Care and Counselling Subcommittee
Mark Benjamin, CPE, Youth Group
Daphne Osborne, CPE, Education Subcommittee
Chandia Williams, Volunteer
Susan Hogg, RGN, Education Subcommittee
Kellye A. McKenzie, US Peace Corps Volunteer & Youth Program Mentor
Sheila Middaugh, US Peace Corps Volunteer

Regional Health Offices

Andrea Campbell, Regional Coordinator for Community Peer Counsellors, Southeast Region
Marelene South, CPE Southeast Region
Carol Cooke, CPE Southeast Region
Angela Harvey, CPE Southeast Region
Rhys Campbell, Youth Ambassador, Ministry of Local Government, Youth & Community Development
Frank Beecher, Regional BCC Coordinator, Northeast Region
Reynaldo Holder, Regional Technical Director, Northeast Region
Marcia Reid, Regional BCC Coordinator, Western Region
Alexander Konstantinov, Regional Technical Director, Western Region
Sheila Campbell-Forrester, Regional Director, Western Region
Michael Coombs, Regional Technical Director, Southern Region
Beverly Wright, Senior Medical Officer, Manchester, Southern Region
Sonia Copeland, Senior Medical Officer, Clarendon, Southern Region
Alice Gabbidon William, Program Development Officer, Southern Region
James Taylor, Contact Investigator/Regional Supervisor, Southern Region

Nongovernmental Organizations & Private Sector

Lois Hue, Director, Jamaica Red Cross (Chairperson NAC Education Subcommittee)
Ian McKnight, Executive Director, Jamaica AIDS Support (former Chairman NAC Care/Counselling Subcommittee)
Ainsley Reid, Chairman, Jamaican Network of Seropositives (Chairman NAC Care/Counselling Subcommittee)
Donna Reynolds, Administrator, Mustard Seed Home
Joseph Robinson, Director, Ashe Caribbean Performing Foundation
Paulette Bellamy, Deputy Director, Ashe
Hally Mahler, FHI Technical Advisor, Ashe
VIBES Performers, Ashe Academy Performing Ensemble
Maxine Wedderburn, Manager, HOPE Enterprises, Ltd
Audrey Anderson, Consultant (former Manager, Condom Social Marketing, AIDS/STD Project)
Yasmin William, Assistant Secretary, Medical Association of Jamaica
William Brown, Honorary Secretary, Medical Association of Jamaica
Olivia McDonald, Executive Director, National Family Planning Board
Osmond Tomlinson, Private Physician
Rabindranath Sahooy, Private Physician
Commercial Sex Workers - Corinne, Sharon, Wanda, Jenny, Veronica
Hotel Workers - Patrick, Donovan, Lanny, Andre, Leonard, Valerie, Marcia, Vivian

UNAIDS Theme Group and Partners on HIV/AIDS

Manuel Pena, Representative, PAHO/WHO
Guillermo Troya, Health Systems Development Officer, PAHO/WHO
Mary Rankin, Health Systems Development Officer, PAHO/WHO
Laila Ismail Khan, Representative, UNICEF
Bridget Levy, HIV/AIDS Advisor, UNICEF
Andrew Wells, Senior Legal Advisor, UNDCP
Anne Marie Campbell, GTZ Program Manager, MOH

USAID / Jamaica

Mosina Jordan, Mission Director

Sheila Lutjens, Director, Office of General Development

Richard Loudis, Director, Office of Program Development & Management

Bridget Fong Yee, Program Management Assistant/Health

Jennifer Knight-Johnson, Project Specialist/Health

Claire Spence, Deputy Director, Office of Health & Education

Joan Davis, Project Management Specialist/Education

Marsha Rigazio - Project Officer/Health (AIDS/STD Project from 1996 to June 2000)

USAID / Washington

John Novak, Monitoring & Evaluation Advisor, GPHN/HIV-AIDS Division

Clif Cortez, Policy Advisor, GPHN/HIV-AIDS Division

Margaret Farrell, Senior Technical Advisor, LAC Bureau

Karen Cavanaugh, Health Systems Advisor, GPHN/HN

John Coury, Regional Coordinator, LAC Bureau

Leola Thompson, Program Officer, PHN Center/GPHN/OFPS

APPENDIX B
SCHEDULE OF VISITS

SCHEDULE OF VISITS

- September 28 USAID/Washington LAC Bureau and GPHN/HIV-AIDS Division
- October 01 Arrival in Kingston
Evaluation Team planning meeting
- October 02 Entry meeting with USAID/Jamaica
Ministry of Health - Deanna Ashley, Yitades Gebre, Althea Bailey,
Alfred Braithwaite, Valerie Marshal
GTZ - Ann Marie Campbell
- October 03 USAID - Sheila Lutjens, Marsha Rigazio
NAC - Lystra Sharpe
PAHO - Manuel Pena, Guillermo Troja, Maria Rankin
Jamaica Red Cross - Lois Hue
- October 04 Jamaica AIDS Support - Ian McKnight
HOPE Enterprises - Maxine Wedderburn
UNICEF - Laila Ismail Khan, Bridget Levy
MOH South East Region - Andrea Campbell, CPEs, Youth Ambassador
- October 05 Medical Association of Jamaica - Yasmin Williams, William Brown
MOH - Paul Gordon
PAC/KSA - Patirck Cunningham, Sharon Dawson, Steven Robinson
JN+ - Ainsley Reid
- October 06 USAID - Sheila Lutjens, Richard Loudis
NPHL/MOH - Evadne Williams
Mustard Seed - Donna Reynolds
MOH - Yitades Gebre
- October 07 Evaluation Team progress review meeting
- October 09 Arrival in Ochos Rios
MOH Northeast Region - Reynaldo Holder, Frank Beecher
PAC/Portland - Dorothy Blake, Sub-committee chairs, Youth Group, CPEs, CI,
US Peace Corps Volunteers
- October 10 Arrival in Montego Bay - Alexander Konstantinov, Marcia Reid
- October 11 Arrival in Kingston
MOH Western Region - Sheila Campbell-Forrester
MOH - Althea Bailey, Alfred Brathwaite
NAC - Howard Hamilton
- October 12 MOH - Peter Figueroa, Colette Myrtle
- October 13 Ashe - Josephe Robinson, Paulette Bellamy, Hally Mahler, VIBES Performers
MOH - Dr. Figueroa, USAID/W Caribbean Initiative Planning Team
MOH Southern Region - Michael Coombs, Beverly Wright, Sonia Copeland,
Alice Gabbidon Williams, James Taylor
- October 14 Evaluation Team report preparation meeting
- October 16 First drafts of report sections
- October 17 National Family Planning Board - Olivia McDonald
MOH - Yitades Gebre, Alfred Brathwaite

October 18 MOH - John Junor, George Briggs, Yitades Gebre
October 19 First draft of report completed and reviewed
October 20 Presentation of draft report to USAID and MOH
October 21 Departure from Kingston

APPENDIX C
DOCUMENTS REVIEWED

DOCUMENTS REVIEWED

National HIV/STD Prevention & Control Project

1. Quarterly Report, April-June 2000
2. Quarterly Report, October-December 1999
3. Supplementary Report, HIV/STD Surveillance 1999
4. Annual Report, 1998-1999
5. Annual Report, 1997-1998
6. NHCP Medium-Term Plan 1997-2001
7. National HIV/STD Prevention & Control Program, *Facts and Figures*
8. Work Plan and Capacity Building Budget FY 2000/2001

Epidemiology Unit – Ministry of Health

9. National HIV/STD Control Programme, *STI Control Component*, Report 1999/2000
10. Contact Investigation Field Guide Manual, 1999
11. Request for AIDS Control Grants, August 1996
12. *STI/HIV Surveillance: Role and Impact of the Contact Investigator*, A brief overview by Dr. Alfred Brathwaite, Epi News, April 2000

National AIDS Committee

13. News Letter, Volume 1, Number 2, April 2000
14. News Letter, Volume 1, Number 1, December 1999

Parish AIDS Committee & Non-Governmental Organizations

15. Strategic Plan 1999-2000, Portland AIDS Committee
16. Second Annual Report 1999-2000, Portland AIDS Committee
17. *AIDS is everybody's business*, Portland AIDS Committee, January 2000
18. Schedule of Activities & Budget October 2000-September 2001, Jamaica AIDS Support
19. *Love, Action, and Support*, Jamaica AIDS Support
20. *Seropositives Release*, Volume 1, Number 1, Jamaican Network of Seropositives, September-December 2000
21. *Together We Can Action* Activity Kit – Peer Education Project, Jamaica Red Cross
22. *Preparing for the VIBES in the World of Sexuality*, Activities Workbook and Facilitator's Manual, Ashe Caribbean Performing Foundation, Kingston, August 1999

USAID / Jamaica

23. Project Paper: AIDS/STD Prevention & Control, Amendment Number 2, September 1996
24. Amendment No. 12 to the Project Grant Agreement Between the Government of Jamaica and the United States of America for the AIDS/STD Prevention and Control Project
25. Project Grant Agreement Between the Government of Jamaica and the United States of America for AIDS/STD Prevention and Control Project, August 1988
26. Bilateral Assistance Strategy FY 2000-2004 (Health Sector only), September 1999
27. Results Review & Resource Request (Health Sector only), March 2000

United Nations and International Organizations

28. *Towards an Integrated Plan of Action 2000-2001*, United Nations Theme Group on HIV/AIDS, Jamaica
29. Jamaica Integrated Plan 2000-2001, UN Theme Group and Partners on HIV/AIDS
30. Strategy Paper: 2002-2006 Country Programme of Cooperation, UNICEF/Jamaica
31. Epidemiological Fact Sheet on HIV/AIDS and STIs in Jamaica, 2000 Update, UNAIDS

32. HIV/AIDS in the Caribbean: Issues and Options, A background report, The World Bank (Latin America and Caribbean Region}, June 2000
33. The Caribbean Regional Strategic Plan of Action for HIV/AIDS, Caribbean Task Force on AIDS, Draft August 2000
34. International Partnership Against AIDS in the Caribbean, Discussion Paper, Hans Moerkerk, UNAIDS, September 2000
35. *Key Elements in HIV/AIDS Care and Support*, Draft Working Document, WHO/UNAIDS, Geneva, September 2000
36. *Lives Together, Worlds Apart*, The State of World Population 2000, UNFPA
37. *Monitoring & Evaluation Guide and Methods Packages for National AIDS Programmes* UNAIDS, Geneva, June 2000

Surveys & Studies

38. *National Survey of Sexual Knowledge, Attitudes, Practices and Behaviour*, Preliminary Findings (to be reviewed by Epi Unit), Hope Enterprises Ltd, October 2000
39. *Behavioural Sentinel Surveillance of CSWs, ICIs and Out-of-School Youth*, Preliminary Findings (to be reviewed by Epi Unit), Market Research Services, October 2000
40. *Adolescent and Young Males Sexual and Reproductive Health Study, Jamaica*. Report to the Pan American Health Organization, B. Chevannes and H. Gayle, Mona, University of the West Indies, September 2000
41. *Peer Education and HIV AIDS: Past Experience, Future Directions*, Population Council/ HORIZONS Project, UNAIDS and Jamaican Ministry of Health, May 2000
42. *Condom Availability, Affordability and Market Size Survey*, Hope Enterprises Ltd., Kingston, April 2000
43. *Contagious Bodies: Multiple Narratives from a Jamaican HIV/AIDS Hospice*, Master of Arts Thesis, Pierre Sean Brotherton, York University, Ontario, Canada, August 1998
44. *Improving sexually transmitted disease management in the private sector: the Jamaican experience*, Margaret Green, Alfred Brathwaite, Maxine Wedderburn, Peter Figueroa, et.al., AIDS 1998, No 12, North Carolina, USA
45. *Knowledge, attitudes, beliefs and practices (KABP) about HIV/AIDS among youth aged 12-14 in Jamaica*. Maxine Wedderburn; Joseph Amon; Peter Figueroa, International Conference on AIDS. 1998
46. *Monitoring and Evaluation of the HIV/AIDS/STD Control Program in Jamaica: An Analysis*, Karen Lewis-Bell, Alfred R. Brathwaite, J. Peter Figueroa, MEASURE Evaluation, North Carolina, September 1998
47. *Regional Accomplishments and Lessons Learnt*. Ricardo M. Calderon, AIDSCAP/FHI, Arlington, Virginia, December 1997
48. Report of the Final Evaluation for Series of STD Seminars conducted for private doctors in Jamaica, Hope Enterprises Ltd., Kingston, Jamaica, April 1996

APPENDIX D
STATEMENT OF WORK

USAID/JAMAICA AIDS/STD PREVENTION & CONTROL PROJECT EVALUATION

STATEMENT OF WORK

BACKGROUND

The AIDS/STD Prevention and Control Project, authorized by USAID/Jamaica in August, 1988, initially provided for \$2.5 million to support activities through August 31, 1994. The initial goal (implemented through AIDSCAP) was to improve the health of the Jamaican people, while the project purpose was to reduce both HIV/STD transmission and the incidence and prevalence of STIs in Jamaica. Initial project activities focused on strengthening three key areas: (1) the Ministry of Health's (MOH) HIV/AIDS/STD surveillance program; (2) public education programs; and (3) interventions which targeted at-risk groups. Project resources supported long and short-term technical assistance, in-service and overseas training for health providers, computer hardware and software, STD pharmaceutical and medical supplies, training materials, and salary support for staff of the Epidemiology Unit (Epi Unit) of the MOH.

In May 1992 the project was amended to provide an additional US\$3,000,000 in grant funds and to extend the life of the project to August 31, 1997. While the project goal and purpose remained unchanged, there were modifications in the design which re-focused activities to include: expanding and improving condom use and distribution; encouraging reduction in numbers of sexual partners; and, improving diagnosis and treatment of sexually transmitted diseases.

In 1995, an external evaluation was conducted and noted that the bilateral agreement had provided the GOJ an outstanding opportunity to systematically plan and implement an effective program for preventing the spread of STIs and HIV. However, the evaluation noted a number of lessons learned including: the need to strengthen the STI facilities island-wide; the importance of increasing demand and access for condoms; and the need to develop effective strategies to promote safe sex and partner reduction. In addition, it pointed to the need for specific targeting of those most at risk of infection with HIV or an STI, enhancing collaboration between family planning and AIDS activities, and improving management of the EPI Unit.

The Mid-Term Evaluation recommendations included:

- 1) Target groups based on socio-cultural and economic boundaries, especially young males, and promote dialogue with all target groups.
- 2) Consolidate STD and surveillance activities, and the Contact Investigator program.
- 3) Establish new management tools at AIDSCAP Jamaica and promote capacity building over the life of the next project cycle. (AIDSCAP technical assistance and long-term presence ended in Jamaica in 1996).

In July 1996, a management review of the Epidemiology Unit of the Ministry of Health was performed to determine their capability to assume total management responsibility for the project, should the institutional contractor AIDSCAP be phased out.

In response to the evaluation findings, on August 9, 1996, the project was further amended to make the Epidemiology unit responsible for managing the USAID resources for BCC, surveillance and research and social marketing portions of the NHCP. The amendment also provided an additional \$5,117,414, and increased the life of project funding to \$10,115,000.

The project goal was revised to "**reduce the rate of increase in transmission of human immunodeficiency virus and the incidence and prevalence of sexually transmitted diseases in Jamaica**" and the project purpose revised to "**reduce high risk sex behavior among target groups in Jamaica**".

In order to achieve the revised goal, the program was refocused to the following areas: Behavior Change and Communication (BCC); STD Control; and Condom social marketing. Complementary to these more technical areas, resources are also being directed towards strengthening the Epi Unit's management and technical skills as well as the management capacity of the National AIDS Committee (NAC).

In 1998, USAID/Jamaica, revised its health sector Strategic Objective (SO) to: "Improved Reproductive Health of Youth". Activities under this SO include the AIDS/STD Control and Prevention Program as well as a new activity in adolescent reproductive health.

OBJECTIVE OF THE EVALUATION:

The objective of the evaluation is to (1) assess the strengths and weaknesses of the project design and lessons learned and; (2) on the basis of that assessment, provide recommendations that would strengthen the present approaches that could be implemented in the short-term; and, (3) design a long-term follow-on activity.

STATEMENT OF WORK:

The key aspects of the Project to be addressed are listed below:

1. Approach:

The project interventions focus on strengthening the capacity for HIV/AIDS/STD surveillance and promoting behavior change to reduce the frequency of different sexual partners and other high-risk sexual behaviors. In addition, the project aims at promoting the use of condoms and improving the quality of STD services. .

Questions that should be addressed are:

- Are the interventions effectively applying the above strategies?
- Does the approach need to be revised or reinforced?
- How effective has the project been at integrating its components into health care systems at various levels?
- Is the input level adequate or too high/low for the intended outputs? Has the absorptive capacity of implementers been reached?
- Is capacity building taking place? What further efforts need to be taken?
- What proportion of the financial and technical resources were contributed by the government?

Primary Responsibility – Team Leader

2. Behavior Change Communication:

The project has focused on behavior change efforts through targeted interventions to high-risk groups, mass media prevention strategies and counseling for HIV/AIDS/STD patients. The project also addressed issues which are inhibiting greater condom use among men and women.

Questions that should be addressed are:

- Is there a clearly defined strategy (BCC), or what is the implied strategy given the multiple interventions that have been carried-out under this component? What are the strengths/weaknesses and lessons learned? How can the strategy be strengthened in the immediate future and recommendations for the follow-on?
- What impact-type data is or might be available regarding the training received (under each component)? Health educators, peer educators, contact investigators, regional coordinators. How did participants utilize training received?
- How effective are interventions to reach targeted groups such as CSW/GoGo dancers and Men With Men (MWM) groups (from the perspective of these group members). How might these interventions be strengthened?
- What are the strengths and weaknesses of activities conducted by the peer educators (a sample from the 50 peer educators supported under the project)?
- How successful has the BCC team been in implementing targeted community interventions? What are the lessons learned and barriers/constraints encountered?
- What has been the extent of the financial support from the government for these activities?

Primary Responsibility – Behaviour Change Communication Specialist

3. Sexually Transmitted Disease Control:

Activities focus on reducing STDs as a cofactor in the transmission of HIV infection to individuals at increased risk. STD treatment centers were established in each of the 13 parishes and healthworkers have received training in case management (syndromic management). Furthermore, the MOH adopted contact investigation as an aggressive form of partner notification for HIV and syphilis. Data on HIV and AIDS is collected from private and public laboratories, clinics and private physicians, analyzed and reported by the Epi Unit. The data is used by USAID to report on its indicators. As a result of the upgrading of the MOH's database, reports from the parishes are transmitted more rapidly to the Epi Unit.

Questions that should be addressed are:

- How reliable are the data reporting mechanisms at the STD clinics? What have been the barriers to capturing the data from the clinics? How might they be resolved before extending the training in syndromic management in Primary Health Care centers (non-STD clinics)?
- What are the prescriptive practices of physicians (private) who have attended training in syndromic management of STIs?
- What outreach program activities are being conducted by the STD component?
- What effect has Health Services Regionalization had on the continuity of the HIV/STD prevention activities?
- What proportion of the financial and human resources were contributed by the government?

Primary Responsibility - Public Health Specialist

4. Condom Social Marketing:

This activity was to look at how best to increase a consistent demand and supply of condoms, promote sustained use and establish at least 2,000 non-traditional condom outlets (e.g., at bars, beauty shops and street vendors) islandwide.

Questions that should be addressed are:

- What were the lessons learned under this component? What are the strengths/weaknesses? Are there any gaps that can be filled?
- What role might the follow-on project take in the area of condom social marketing and how might these activities link with the new ARH Program?
- What proportion of the costs were contributed by the government? Will the government be able to increase its contribution to meet the additional costs for expanding these activities?

Primary Responsibility – Behaviour Change Communication Specialist

5. Capacity Building - Epidemiology Unit

Interventions focus on strengthening the management capability of the Epi Unit in order to make maximum use of donor assistance and enhance the efficiency and effectiveness of its operations. Capacity building was through management training, team building and change management workshops.

Questions that should be addressed are:

- How effective were the management training, team building and change management workshops in strengthening the management capability of the Epi Unit?
- Was donor assistance sufficient to enhance the efficiency and effectiveness of its operations?
- What is the turnover rate of trained CPEs and other staff? How many of the positions are being funded by GOJ? What additional measures are being taken to fund all positions?

Primary Responsibility - Team Leader

6. National AIDS Committee (NAC)

The goal of the project was to enable the NAC to: 1) become a critical force in facilitating national policy formulation and public awareness; 2) mobilize private sector support and raise funds; and , 3) strengthen the NAC's efforts in coordinating and mobilizing its member organizations and sub-committees.

Questions that should be addressed are:

- How influential is the NAC in facilitating the national policy formulation process and raising public awareness?
- How successful is the NAC in mobilizing private sector support and raising funds?
- How might the linkages, interactions, roles and responsibilities between/among the NAC and Parish AIDS Committees (PACs) be strengthened.
- What is the perception from the PACs of the role and responsibilities of the NAC.

Primary Responsibility - Public Health Specialist

1. Future Direction:

Based on the progress to date the Team is will make recommendations regarding the initiation of new activities for the follow-on HIV/AIDS prevention and control program targeted to the 10-19 year olds but not limited to this age group.

Primary Responsibility – Team Leader and Team Members

METHODOLOGY

In order to examine the above issues, the following methodology should be considered:

- Review of documents such as project paper, project agreement, project amendments, project implementation letters, tripartite agreement, Result Review and Resources Request (R4) etc.;
- Meetings and discussions with concerned officers at USAID, MOH, NAC, PACs, other donors;
- Review of monitoring and evaluation reports;
- Site visits to project-funded areas
- Interaction with target groups;
- Other information such as case studies, observational and anecdotal data may also be used as appropriate.

REPORTING REQUIREMENTS:

The consultant(s) undertaking the evaluation/assessment phase (Evaluation Team) of this Scope of Work (SOW) will conduct an initial briefing with the Director, Office of General Development, Project Officer, Mission Evaluation Officer, other members of USAID/Jamaica staff and MOH counterparts to present a schedule of activities to carry-out the evaluation including a timeline and once a week briefing thereafter.

The contractor will submit a draft evaluation report (6 copies) to USAID and the MOH for their review no later than one day prior to the final briefing. USAID/Jamaica and the MOH will have 1 week to provide comments to the draft after which the contractor will have 2 weeks to incorporate these comments and 1 week to edit, proof and print the final evaluation report (6 copies).

The appendices will include at a minimum the following:

- a bibliography of documents consulted;
- a list of institutions and individuals consulted; and
- other documents relevant to this evaluation.

PERFORMANCE PERIOD

The expected period of performance in Jamaica will be from October 2, 2000 through October 20, 2000. The schedule for completion of objective (1) and objective (2) will be as follows:

Week 1:

- Initial briefing with USAID/J staff, OGD Director, Evaluation Officer/Program Office, technical staff. Contracting specialist;
- Initial meeting with MOH staff, Epidemiology Unit, MOH Project Officer;
- Interviews with key component heads of the project - BCC Coordinator, NAC, STI Component Head
- Meet with Regional Director, Kingston/St. Andrew
- Meet with donors - UNICEF, PAHO, GTZ
- Meet with NGOs - JAS, JN+, and others

Week 2:

- Visit four regions to meet with Parish AIDS Committees, BCC Coordinators, Regional Directors and Senior Medical Officers

Week 3:

- Complete regional visits
- Follow-up meetings with USAID, MOH, component heads as necessary
- Draft Report
- Debrief USAID/J and MOH