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UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
Washington, D. C. 20523

JAMAICA

PROJECT PAPER

AIDS/STD PREVENTION AND CONTROL

AID/LAC/P-454

Project Number: 532-0153

UNCLASSIFIED

AGENCY FOR INTERNATIONAL DEVELOPMENT
PROJECT DATA SHEET

1. TRANSACTION CODE: **A** (A = Add, C = Change, D = Delete) Amendment Number: _____ DOCUMENT CODE: **3**

COUNTRY/ENTITY: **JAMAICA**

3. PROJECT NUMBER: **532-0153**

4. BUREAU/OFFICE: **LATIN AMERICA AND THE CARIBBEAN** LAC: **05**

5. PROJECT TITLE (maximum 40 characters): **AIDS/STD PREVENTION & CONTROL**

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): **08/31/94** (MM/DD/YY)

7. ESTIMATED DATE OF OBLIGATION (Under "B" below, enter 1, 2, 3, or 4):
A. Initial FY: **88** B. Quarter: **4** C. Final FY: **93**

8. COSTS (\$000 OR EQUIVALENT \$1 =)

A. FUNDING SOURCE	FIRST FY 88			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	50	490	540	482	2018	2500
(Grant)	(50)	(490)	(540)	(482)	(2018)	(2500)
(Loan)	(-)	(-)	(-)	(-)	(-)	(-)
Other U.S.:						
1.						
2.						
Host Country	-	55	55	-	850	850
Other Donor(s)						
TOTALS	50	545	595	482	2868	3350

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) HE	513	550	-	-	-	500	-	500	-
(2) AIDS	513	550	-	-	-	1500	-	1500	-
(3) POP	513	550	-	-	-	500	-	500	-
(4)									
TOTALS						2500	-	2500	-

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): **530**

11. SECONDARY PURPOSE CODE: **500**

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each):
A. Code: **BRW** **BUW**
B. Amount: _____

13. PROJECT PURPOSE (maximum 480 characters):

TO REDUCE HIV TRANSMISSION AND THE INCIDENCE AND PREVALENCE OF STDs IN JAMAICA.

14. SCHEDULED EVALUATIONS: Interim **02/92** Final **01/94** (MM/YY)

15. SOURCE/ORIGIN OF GOODS AND SERVICES: 000 941 Local Other (Specify) _____

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page PP Amendment):

USAID/Jamaica Controller has reviewed and concurs with the methods of implementation and financing included herein.

Robert Leonard
Robert Leonard - Controller

17. APPROVED BY: **WILLIAM R. JOSLIN** (Signature) **DIRECTOR, USAID/JAMAICA** (Title)

Date Signed: **1/18/2013** (MM/DD/YY)

18. DATE DOCUMENT RECEIVED IN AID/FW, OR FOR AID/FW DOCUMENTS, DATE OF DISTRIBUTION: _____ (MM/DD/YY)

PROJECT AUTHORIZATION

Name of County: Jamaica
Name of Project: AIDS/STD Prevention and Control
Number of Project: 532-0153

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the AIDS/STD Prevention and Control Project for Jamaica involving planned obligations of not to exceed Two Million Five Hundred Thousand United States Dollars (US\$2,500,000) in grant funds over a six year period from date of authorization, subject to the availability of funds, in accordance with the A.I.D. OYB allotment process, to help in financing foreign exchange and local currency costs for the Project.

2. The Project will (1) develop and strengthen the AIDS/STD policy and program planning and monitoring systems; (2) educate the public and relevant professional groups about AIDS and STD prevention, and develop and implement prevention and intervention strategies to reach those most at risk including pregnant women and young adults; and (3) strengthen the institutional capability of the Ministry of Health to plan and manage comprehensive AIDS/STD control strategies.

3. The Project Agreement, which may be negotiated and executed by the officer to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority, shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate.

4.a. Sources and Origin of Commodities, Nationality of Services

Commodities financed by A.I.D. under the Project shall have their source and origin in Jamaica or in the United States except as A.I.D. may otherwise agree in writing. Except for ocean shipping, the suppliers of commodities or services shall have Jamaica or the United States as their place of nationality, except as A.I.D. may otherwise agree in writing.

4.b. Ocean Shipping

Ocean shipping financed by A.I.D. under the Project shall, except as A.I.D. may otherwise agree in writing, be financed only on flag vessels of the United States.



William R. Joslin
Director
USAID/Jamaica

7.23.85

Date

Clearances

OPPE:PLerner PLerner
CONT:RLeonard RC 8/11
OHNP:JCoury JPC 8/17/85
OHNP:RCohn (draft)
OHNP:GGrey (draft)
OPEP:PCrowe PC 8/14/85
OPEP:RBaker RBaker
A/DDIR:TTifft TTifft
(Drafted:OPDS:Boyer)
RLA:RJohnson (telcon)

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Clearances

OPPE:PLerner *PLerner*
CONT:RLeonard *RL*
OHNP:JCoury *JC*
OHNP:GGrey *GG*
OPEP:PCrowe (reviewed in draft) *PC*
OPEP:RBaker *RB*
A/DDIR:CMatthews *CM* *RC*
(Drafted: OPDS:BC/ser/OHNP:RCohn)
(0601U, 0602U)

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List of Acronyms

ACOSTRAD	Association for the Control of Sexually Transmitted Diseases
AIDS	Acquired Immune Deficiency Syndrome
AIDSCOM	A.I.D. centrally funded project dealing with AIDS communication and information activities
AIDSTECH	A.I.D. centrally funded project dealing with the technical aspects of AIDS prevention
ARC	AIDS Related Complex
ARP	Administrative Reform Program
CAREC	Caribbean Epidemiology Center
CDC	Centers for Disease Control, Atlanta
CIDA	Canadian International Development Agency
EEC	European Economic Community
GOJ	Government of Jamaica
GSA	General Services Administration
HC	Host Country
HIV	Human Immuno-deficiency Virus
HTLV	Human T-Cell Lymphotropic Virus
HTLV-I	Human T-Cell Lymphotropic Virus, Type 1
IQC	Indefinite Quantity Contract
JAMAL	Jamaican Movement for Adult Literacy
JIS	Jamaica Information Service
KAP	Knowledge, Attitude, and Practice
KPH	Kingston Public Hospital
MCH	Maternal and Child Health
MOH	Ministry of Health
MOL	Ministry of Labor
NFPB	National Family Planning Board
OPG	Operational Program Grant
PACD	Project Assistance Completion Date
PAHO	Pan-American Health Organization, the regional office of WHO
PCC	Project Coordinating Committee
PID	Pelvic Inflammatory Disease
PIU	Project Implementation Unit
pm	person month
PMO	Principal Medical Officer
PSA	Procurement Services Agent
PVO	Private and Voluntary Organization
REACH	Resources for Child Health Project
SMOH	Supervisory Medical Officer of Health
SOMARC	Social Marketing of Contraceptives Project
STD	Sexually Transmitted Disease
WHO	World Health Organization

I. SUMMARY AND CONCLUSIONS

A. Project Summary

The Government of Jamaica has developed a national plan of action for AIDS and Sexually Transmitted Diseases (STD) prevention and control and the Project's activities are part of this national plan. The Project will: (1) develop and strengthen the AIDS/STD policy and program planning and monitoring systems; (2) educate the public and relevant professional groups about AIDS and STD prevention, and develop and implement prevention and intervention strategies to reach those most at risk including pregnant women and young adults; and (3) strengthen the institutional capability of the Ministry of Health to plan and manage comprehensive AIDS/STD control strategies. The Project will be implemented by the MOH under a bilateral agreement, with a subgrant to ACOSTRAD.

B. Summary Findings

Jamaica suffers from dramatically increasing rates of AIDS cases and extremely high rates of STDs, including pediatric AIDS cases and congenital syphilis. Experience to date in other countries demonstrates that an AIDS and STD prevention campaign can have a significant impact on preventing the spread of AIDS and STDs in Jamaica. It is estimated that an effective AIDS prevention program could avert between 15-30 million dollars in treatment costs alone, costs that the GOJ is not financially capable of meeting.

The Project is consistent with the Jamaican Country Development Strategy Statement which includes AIDS and STDs as one of three priority areas in the Jamaican Health Sector. The Project will be coordinated with WHO/PAHO in accordance with Agency wide policy, and with EEC and other donor assistance to the Jamaican National AIDS Program.

The immediate beneficiaries of the Project will be the men and women at risk of developing AIDS and STDs, and their children. All Jamaicans will benefit if the negative impact of AIDS and STDs is minimized, especially as it affects the cost of health care.

C. Project Paper Design Team

The Project Paper was prepared by USAID/Jamaica's Project Development and Health, Nutrition and Population Offices, based upon a report prepared by Policy Research Incorporated.

II. PROJECT RATIONALE AND DESCRIPTION

A. Rationale

1. Background: Relevant Health Status and Social Indicators in Jamaica

The health status of Jamaicans is better, on the average, than that of inhabitants of most other countries in the Latin American/Caribbean region, but still reflects Jamaica's status as a developing country. The island had a population of 2,355,100 in 1987, an increase of 0.4% over 1986.^{1/} The age groups most at-risk for AIDS are young and middle age adults; the 15-59 age group in Jamaica comprised 49% of the population in 1985.^{2/}

Life expectancy at birth was 70 for Jamaica in 1983^{3/}, in comparison with 75 for Cuba, 72 for Barbados (the two Caribbean countries with the longest life expectancy averages), 54 for Haiti, and 60 for the LAC region as a whole. It also has a relatively low infant mortality rate: 27/1,000 live births, in comparison with 17/1,000 for Barbados (the LAC country with the lowest infant mortality rate), 28/1,000 for Trinidad and Tobago, and 107/1,000 for Haiti. It has the fourth highest life expectancy in the Caribbean and the fourth lowest infant mortality rate.^{4/5/}

The rate of literacy in the population is an important determinant of the types of AIDS and STD prevention strategies that are feasible and likely to be most effective. World Bank documentation tentatively estimated Jamaica's 1984 literacy rate to be 90%^{6/}. However, a recent report by the Jamaican Movement for Adult Literacy (JAMAL)^{7/} suggested that 24% of all Jamaicans were functionally illiterate.

Nutrition, stress and drug use -- including alcohol use -- have been described as possible AIDS co-factors.^{8/9/10/} Increases in tuberculosis cases have occurred along with increases in AIDS cases in a number of countries, and possible links between them have been hypothesized.^{11/} In order to begin to consider these health problems in the context of AIDS and STD prevention strategies in Jamaica, a brief review of these health indicators in Jamaica is presented.

Nutrition - The average per capita caloric consumption is 111% of requirements, but this varies considerably by economic group.^{12/} A recent report^{13/} indicated that nationally there are no specific nutrient deficiencies (other than principally nutrition and anemia-related deficiencies noted in pregnant women), but that caloric intake is inadequate among some of the poorer Jamaicans. Over-consumption of specific nutrients occurs in certain groups.

Drug and Alcohol Abuse - The first national survey of drug abuse in Jamaica was recently completed, and the final report is being prepared.^{14/} Unofficial reports indicate that marijuana (cannabis) is used by 40-50% or more of the population age 15-64.^{15/} Although there have been no national surveys of alcoholism in Jamaica since that conducted by Beaubrun in 1966, a 1985 World Health Organization Report showed a substantial increase in per capita consumption of alcohol during the period 1973 to 1981: from 21.9 liters to 27.0 liters.^{16/}

A recent post-primary school study of drug use in Jamaica showed that 33% of students in grades 7-13 (ages approximately 11-18) had used alcohol in the 30 days prior to the survey, 9% had used cannabis in some form, 10% had used inhalants, 0.9% had used cocaine and 0.9% had used crack.^{17/} In 1985, a comparable study conducted in the U.S. showed that 31% of students in the same age group had consumed alcohol in the previous 30 days, and 12% had smoked cannabis.^{18/}

Stress-related Illness - Hypertension is common in Jamaica. In 1986, hypertension was the second leading reason for outpatient visits. In addition, cardiovascular conditions have been among the three leading causes of death in Jamaica for several years. Hypertensive disease specifically was the fifth leading cause of death for the 15-44 age group in 1982 and the fourth leading cause of death for age groups 45-64 and 65 and older in the same year.^{19/} Two other indicators of stress -- spouse and child abuse -- are also reportedly high.^{20/}

Tuberculosis - From 1980 to 1987, the number of reported tuberculosis cases in Jamaica has varied considerably, with no clear trend. Incidence increased from 172 in 1980 to 222 in 1984 and decreased to 96 in 1986.^{21/} The following year, the number of TB cases reported by the National Chest Hospital again increased, to 133.^{22/} Some MOH officials state that this increase may reflect a reactivation of old cases.

2. The Problem

a. The Epidemiology of AIDS and STDs in Jamaica. Both AIDS and STDs have significant impact on the Jamaican health care system, in terms of delivery of health services, the concomitant utilization of personnel, facilities and other health resources, and the cost of prevention and treatment. The epidemiologic trends in AIDS and other STDs are summarized in this section of the Project Paper.

(1) Trends of AIDS Cases and HIV Seroprevalence in Jamaica

AIDS Cases - The first case of AIDS in Jamaica was diagnosed in 1982. As of May 21, 1988, the total number of confirmed cases was 59. Of the 59 total cumulative cases, 33 were diagnosed in 1987

and 15 were diagnosed in the first months of 1988. Only 17 of those who had been diagnosed were still living as of May 21, 1988.^{23/} In Jamaica, the average life-expectancy after diagnosis is 3-4 months.

Fourteen of the 53 adult cases (24%) diagnosed as of May 21, 1988, were women, and six of the total cumulative cases (10%) were pediatric.^{24/} Should this proportion of confirmed pediatric cases be sustained, Jamaica would rank among the countries with the highest rates of pediatric AIDS cases. There have been only two cases of transmission of HIV through the blood supply system in Jamaica; both occurred before testing of all donated blood began in 1985.^{25/}

Using data from the end of April 1988, the majority of the cases are from Kingston, but cases have been reported in 11 of the 14 parishes. HIV seropositivity has been reported in all parishes. Until the end of 1986, all of the reported cases were imported; that is, acquired by Jamaicans living or visiting overseas, and five of the 11 cases were homosexual or bisexual males. Since January, 1987, the picture appears to have changed dramatically: only 10 of the 43 new cases since then have been imported, and only eight have been determined by self-report to be homosexual or bisexual. The contact location (i.e., imported or local) is unknown for 15 of the total 54 cases, and sexual practices are unreported in six of the 54 cases. These apparent shifts in AIDS risk categories may reflect: 1) changes in screening or reporting of AIDS, 2) rapid continuing transmission of the disease to and among males and females in the heterosexual population, 3) a reluctance to acknowledge certain sexual preferences (which would reduce the number of reported homosexual/bisexual cases and could also result in under-reporting of cases).

The pattern of HIV transmission in Jamaica is distinct from that of the U.S.; that is, Jamaica has much higher percentages of heterosexual and pediatric cases. For example, in the U.S., as of April 11, 1988, heterosexual transmission represented 4% of cumulative confirmed adult cases of AIDS, and pediatric cases represented 1% of total cumulative cases.^{26/} The pediatric cases in particular raise concerns about the potential negative impact of AIDS on child survival gains in Jamaica.

The distribution of AIDS cases in Jamaica reflects the relative distribution of the population by socio-economic class. For example, of the 54 cases as of the end of April, seven have been employed professionals or business owners, nine have been farm workers, five have been prostitutes, four traders (higglers or street vendors), thirteen laborers or lower-middle class workers (e.g., mechanic, bar attendant), and eighteen were not employed or not specified.^{27/} As is evidenced by these data, in Jamaica, as elsewhere, all socio-economic classes are represented. It is

likely that some middle and upper class Jamaicans are being diagnosed (and perhaps receiving treatment) in the U.S., the U.K., or elsewhere and are not included in Jamaica's statistics.

The MOH maintains a registry of HIV+ persons, including the medical symptoms identified through the public health system. The MOH has determined that the U.S. Centers for Disease Control diagnostic categories for AIDS-related conditions (ARC) are not appropriate to Jamaica.^{28/} The Ministry is now beginning to adapt the CDC diagnostic criteria to the opportunistic infections that have been presented in Jamaica, and have designated this as AIDS-Related Conditions. Given current information regarding HIV+ individuals and their medical symptoms, the MOH estimates that approximately 100 of the 200 known living HIV+ individuals without AIDS have AIDS-related Conditions. As diagnostic criteria for Jamaica are clarified, it will be important for the MOH to address the impact of ARC on the health care system and to ensure that health care providers are capable of accurately diagnosing ARC, which has proved problematic in other countries.

Trends in Seroprevalence of HIV - More than 85,000 tests for HIV seropositivity have been conducted thus far through point-in-time studies or on-going seroprevalence screening (e.g., of donations to the MOH Blood Bank). Of these (which were all ELISA tests), 204 have been confirmed as positive through the ELISA and the Western Blot tests.^{29/} Of the 5,511 tests conducted through the U.S. Department of State visa program, one has been confirmed as HIV+, and three are pending confirmation.^{30/}

In interpreting these data, it is important to keep in mind that although the MOH encourages voluntary retesting for those at-risk, the scarcity of resources does not allow for consistent retesting (e.g., after three months) of those HIV antibody negative individuals suspected on epidemiologic or clinical grounds of being likely to convert to HIV+. All of the seroprevalence studies conducted have been point-in-time; that is, only one test was taken for each person who was not HIV+. This is significant; studies have shown that ELISA tests can give false negative results for a year or more after infection, and individuals who are exposed to the virus by virtue of engaging in risk-related behavior could also contract the virus at any point after the test has been taken. However, there may well be unplanned retesting of individuals through the Ministry of Labor (MOL) testing programs, the MOH blood bank and private laboratories.

(2) Sexually Transmitted Diseases in Jamaica - In addition to being a serious public health problem in and of itself, the prevalence of STDs in Jamaica is of concern because of the strong association between STDs and AIDS in other countries ^{31/} and because of the possible role of syphilis as a co-factor in seroconversion and progression from seropositivity to AIDS.^{32/} Some studies have shown that following intensive AIDS prevention

campaigns the incidence of STDs has decreased among the populations at which the campaigns are directed.^{33/} This has been an important consideration in the development of this Project Paper.

Epidemiologic trends in STDs in Jamaica are difficult to assess because since 1983, when reduced resources severely limited the ability of the MOH to collect accurate data, the data have only been estimated. Although reporting improved slightly in 1986, data are still reported from only six of the 14 parishes. The Senior Medical Officer, Health (SMOH) for the STD Unit has indicated that the estimated increase in numbers of cases is most likely indicative of actual substantial increase in STD transmission. In general, after a several year decline in prevalence of gonorrhoea, syphilis, and congenital syphilis, there have been increases since 1986.

Although the rate of reported cases of gonorrhoea decreased dramatically from 1,152/100,000 population in 1980 to an estimated 461/100,000 in 1986, it then increased slightly to an estimated 475/100,000 in 1987. Syphilis increased from 47/100,000 in 1980^{34/} to an estimated 121/100,000 in 1987, with wide fluctuations in the rate between 1980 and 1986. In the first three months of 1988, there were 2,344 reported cases of gonorrhoea and 398 reported cases of syphilis.^{35/} Congenital syphilis increased from 5 cases in 1985 to 16 in 1986 and 36 in 1987. This 36 is the same as the average number of cases for the period 1970-74. In the first quarter of 1988, there were 9 reported cases of this relatively rare form of STD.^{36/}

Beginning in 1985, the age distribution of both syphilis and gonorrhoea began to change, with decreases in the proportion of cases in the age group 10-19. For syphilis, the decrease was from 21% of reported cases in 1985 to 15.8% in 1987, and for gonorrhoea the proportion of cases in this age group declined from 26.5% to 17.1%. In both 1986 and 1987, there were 12 reported cases of syphilis, and in the same years there were 191 and 144 cases of gonorrhoea respectively.^{37/}

There were 127 cases of herpes genitalis in 1987, the first year for which cases were routinely reported by STD clinics.^{38/} In 1987, there were 5,590 cases of non-gonococcal urethritis/cervicitis, a 80% increase over 1983 reported cases. The reported number of trichomoniasis cases increased by 35% during the same period, from 1,489 to 2,004 cases. According to STD clinic reports, candidiasis might have decreased from 1,840 reported cases in 1983 to 1,681 in 1987, although the reader is reminded that only six STD clinics report cases and few private physicians report cases.

Another (non-AIDS) retrovirus that is classified as a STD is HTLV-1 (Human T-cell Lymphotropic Virus, Type I) which causes a

type of leukemia (adult T-cell leukemia/lymphoma) and paralytic nerve disease known as Jamaican neuropathy or tropical spastic paraparesis. This STD is considered by the MOH to be endemic in Jamaica. Based on results of screening of blood donor supplies, there is an estimated overall seroprevalence of 3.2% in men and 6.7% in women; older persons have much higher infection rates.^{39/} In three studies made to determine the prevalence of HTLV-1 in Jamaica, 3.7% of 4,000 food handlers were found to be HTLV-1 positive; 6.9% of 2,400 STD clinic patients were positive; and 8.9% of 123 homosexual men were positive for the virus. Identified HTLV-1 cases have been geographically distributed throughout the country. In the study of homosexual/bisexual men, seropositivity was associated with a higher number of sexual partners and with a history of gonorrhoea infection.^{40/} HTLV-I is not routinely reported, and there is no on-going testing, so even estimated prevalence data are not available. The National Blood Bank and the University of the West Indies are currently planning a study of HTLV-I prevalence, to be funded by the U.S. National Institutes of Health.

It is important to bear in mind that these rates of the prevalence of STDs are largely estimated, and that under-reporting is known to be a significant problem. According to the SMOH for the STD Unit, the actual prevalence of syphilis and gonorrhoea is at least four times the reported figures.^{41/} This is consistent with the findings of a PAHO consultant, who reported that "estimates made by extrapolating from laboratory records show that the true number of cases of syphilis may be up to 7 times the reported figures."^{42/} This problem of under-reporting of cases is addressed directly by the Project, through support for improved testing capability, mass media campaigns, and conduct of prevalence studies).

(3) Estimated Trends of AIDS and STD Cases and HIV Seropositivity in Jamaica through 1993 - Within the context of the current economic situation in Jamaica, the already strained public health system is ill-prepared to deal with the alarming increase in cases of AIDS and certain sexually transmitted diseases, described previously. The potential for devastating socio-economic effects of these diseases, if left unchecked, is enormous.

Although the number of confirmed AIDS cases in Jamaica thus far has been relatively low in comparison with other countries, a minimum estimate of the number of cumulative AIDS cases by 1993 is 1440, assuming doubling of cases each year to 1992 and a 50% increase in cases between 1992 and 1993 (or making projections on the basis of several very optimistic assumptions)^{43/}.

Prevalence of STDs is high in Jamaica, and if no significant improvements in STD prevention and control are made, further increases can be anticipated. The fact that only estimated prevalence data are available renders even simple straight line

projections of trends difficult and of questionable validity. However, in order to consider the future magnitude of this important health problem and its impact on the Jamaican health care system, the SMOH for the STD Unit has estimated a 20% annual increase in actual prevalence of syphilis, which would result in 33,563 cumulative cases between 1989 and 1993. Given the general downward trend in estimated cases of gonorrhoea, with the exception of the small increase in 1987, the SMOH estimates only a 3% annual increase in actual prevalence of gonorrhoea, which would result in 189,775 cumulative cases between 1989 and 1993.^{44/} Although the number of cases of congenital syphilis tripled between 1985 and 1986, and then doubled in 1987, it is highly improbable that this rate of increase would continue. However, it is possible, unless screening is significantly improved and the maternal cases treated, that the cumulative number of cases will exceed 387 between 1989 and 1993, given a 20% annual increase.

b. Current AIDS and STDs Policies and Prevention and Treatment Programs in Jamaica

(1) Public and Private Policies and Programs Concerning AIDS

Organizational Responsibility - The Epidemiologic Unit and the STD Unit of the MOH have been primarily responsible for planning and managing the prevention and control of AIDS and STDs in Jamaica. The Epidemiology Unit has been designated the National AIDS Program Unit. In coordination with the Chief Medical Officer, the Epidemiologic Unit has also guided policy planning concerning treatment of AIDS and coordinates with the Sexually Transmitted Diseases Unit for treatment planning of STD cases. The MOH addresses issues regarding the prevention and treatment of AIDS and STDs in the monthly meetings of the Medical Officers of Health of the 14 parishes, and also receives advice from the Disease Control Committee, which meets every two months and which has been actively involved in consideration of AIDS and STDs policies and programs of the MOH.

The National AIDS Committee was established by act of Cabinet in December, 1987. The Chairman of the Committee was appointed in April, 1988. The Committee includes representatives from the Ministries of Health, Finance, Education, Youth and Labour, the Jamaica Information Service, Jamaica Tourist Board, National Family Planning Board, ACOSTRAD, the Private Sector Organization of Jamaica, the Planning Institute of Jamaica, churches, the legal profession, and the community. It has four subcommittees, as follows: (a) Public Education, (b) Technical, (c) Legal and Ethical, and (d) Fund raising.

Surveillance - The following programs constitute AIDS testing activities that are operated on an on-going basis by the MOH and other entities in Jamaica:

-- On-going testing of MOH blood bank samples (since 1985);

- Testing of individuals suspected on clinical or epidemiological grounds of being HIV+ or of having AIDS;
- Testing by the Ministry of Labor of farm workers applying for visas to work in the U.S. (since 1985);and
- Testing of applicants for U.S. immigrant visas by the American Embassy (since December 1, 1987).

The results of these testing programs have been presented in section B.1.1 above. Contact tracing related to these seroprevalence studies is carried out by MOH staff at the parish level and by STD tracers working for the Epidemiology Unit.

In March, 1988, the MOH initiated a seroprevalence survey of prostitutes for which the Epidemiology Unit and the STD Unit jointly had developed plans in 1986 and for which they had sought, but not received funding from both the MOH and external donor agencies. Technical assistance for planning of the study is currently being provided by USAID and AID/W through the AIDSCOM and AIDSTECH projects.

Prevention - Since 1986, the MOH has developed and implemented mass media campaigns aimed at the general population. These campaigns, which include TV and radio announcements and programs, information brochures, and billboards, have been undertaken in collaboration with the Jamaican Information Service (JIS) and ACOSTRAD. These efforts have included the MOH's preparation and distribution of information brochures, education and orientation of health care workers, and co-sponsorship of meetings and symposia. In January, 1988, ACOSTRAD, a private voluntary organization devoted to prevention of STDs and AIDS, with a sub-contract to the JIS, initiated a major mass media AIDS and STDs prevention campaign. The campaign is funded by USAID through the National Family Planning Board. Prevention messages have been pre-tested (with technical assistance from SOMARC in conduct of the knowledge, attitude and practice - KAP - studies), and revised messages are currently being reviewed by the MOH prior to their use by JIS. Prior to that grant, the Jamaican Information Service had developed and disseminated AIDS prevention materials in cooperation with ACOSTRAD. This included television, radio and monthly video programs distributed through the 14 regional offices of the JIS.

The Ministry of Education is responsible for providing STD education to school-age youth through teachers, guidance counselors and school health nurses. ACOSTRAD has met with representatives of these professions to discuss education regarding AIDS. The Ministry of Education and the Jamaican Information Service also play important roles in STD prevention. The Jamaica National Family Planning Board (NFPB, a statutory board within the MOH) has provided support for AIDS and STD

educational brochures developed by Operation Friendship (a local PVO). The NFPB has also expressed an interest in participating in AIDS and STD prevention programs, including for example, distribution of condoms.

Through its members, ACOSTRAD has distributed AIDS brochures to health care providers, guidance counselors, school health nurses and others since 1983. It has also conducted workshops and seminars, collaborated with the Ministry of Education to include AIDS information in the Family Life public school education series, and held a week-long exhibition on STDs and AIDS (in November, 1987). The Jamaican Red Cross has distributed AIDS educational brochures to various professional and community groups since 1987.

Treatment - All but one of Jamaica's diagnosed AIDS cases have been treated in public secondary care hospitals. Most of the cases have been treated at more than one hospital (e.g., Kingston Public Hospital (KPH), National Chest Hospital and University Hospital). However, KPH and University Hospital have each treated approximately half of the patients. The pediatric cases have been treated at the Bustamante Children's Hospital and at the University Hospital. No known cases have been treated at private hospitals, although two cases have been referred by private hospitals to MOH hospitals for treatment.

AIDS patients in Jamaica have an average of two hospital admissions between diagnosis and death, with an average total of 30 inpatient days. Prior to discharge from hospital, the Public Health Nurse determines if the home environment is adequate for provision of patient care and counsels the patient on preventing transmission of AIDS. A two-week supply of medications for opportunistic infections is provided, and a referral is made to the MOH parish-level Medical Officer of Health. Post-discharge outpatient care is provided at the outpatient department of the admitting hospital or at the nearest, most appropriate MOH facility, depending on the patient's condition. Home visits are made by the parish-level MOH staff to follow-up on the patient's condition and to determine if additional hospitalization is required.

(2) Public and Private Policies and Programs Regarding STDs

The STD Unit has a SMOH, a Chief Contact Investigator, a Senior Contact Investigator and a Secretary. The position of Medical Officer of Health (MOH), which includes supervisory and training duties, is vacant and has been loaned to the Epidemiology Unit. In addition, a Chief Health Educator (who is responsible to the MOH Director of Health Education) and a Chief Medical Technologist (who reports to the MOH for Kingston/St. Andrew Parish) maintain liaison with the SMOH for the STD Unit (and with the MOH for the Unit, when that post is filled). A total of seven Contact

Investigators work at six clinics in six parishes, and an additional five (including the Chief and Senior Contact Investigators) work out of the central comprehensive clinic located in Kingston, being assigned to do contact investigation in other parishes as necessary. The MOH requested that there be a minimum of 39 posts for Contact Investigators in 1975, but thus far only 10 posts have been established, and of these, three are currently vacant. The investigators are responsible for interviewing those individuals identified as being HIV+ and those with STDs in order to identify partners who should be notified.

Surveillance. In Jamaica, the principal STDs of concern are divided into two classes, for purposes of obligatory reporting by physicians; these are:

- Class I STDs -- AIDS and HIV, congenital syphilis, and ophthalmia neonatorum -- should be reported by physicians (or STD clinic personnel) using an STD report form for each identified case. The reports, which identify the infected individual (and the mother, if relevant), are to be submitted to the STD Unit and to the parish-level MOH;
- Class II STDs -- gonorrhoea and syphilis (all positive syphilis serologies) are reported to the STD Unit and the parish-level MOH, by age and total number, not by individual case).

Unfortunately, according to the SMOH for the STD Unit, even most MOH physicians do not routinely report either Class I or Class II STDs. Very few physicians in private practice do so, which is significant because possibly as many as 50% of those who are self-suspected of having an STD do not attend the MOH's STD clinics for diagnosis, but rather go to private physicians.

Prevention. The Health Education Unit of the Ministry of Health works with the STD Unit to develop and disseminate preventive materials regarding STDs. However, since 1978 much of the STD educational activity in Jamaica has been undertaken by ACOSTRAD, which also has coordinated with the Ministry of Education to develop school-based STD prevention and education materials, as it has for AIDS.

Treatment. As mentioned above, it has been estimated that approximately half of those requiring diagnostic work or treatment for STDs do not seek diagnosis or initial or follow-up treatment at MOH facilities. The SMOH for the STD Unit has suggested several reasons for this by-passing of MOH facilities for STD diagnosis and treatment: 1) lack of access to MOH facilities; 2) personal shame; and 3) lack of trust that confidentiality will be maintained.

Reportedly, few of those who are infected are able to afford treatment from a private physician; this implies that a large percentage of persons infected with STDs remain untreated. The SMOH for STDs reports that as many as 10% of the gonorrhoea cases in Jamaica may be presently resistant to penicillin.^{45/} According to a 1984 study conducted at the MOH's Comprehensive Clinic in Kingston, 3% of the gonorrhoea cases were penicillin-resistant.^{46/}

c. Technical, Managerial and Resource Constraints

The ability of the GOJ to undertake effective prevention of AIDS and STDs is severely hampered by technical constraints beyond its control and by managerial and resource constraints only partially within its control. These constraints are described below.

(1) Technical Constraints - There is no vaccine to prevent AIDS, nor cure for the disease, although opportunistic infections can be treated. Moreover, public health authorities in the United States and Europe which are in the forefront of biomedical research have recently reiterated their belief that no such vaccine or treatment will be available for at least 10 years. There are also technical limitations to the accurate and early detection of HIV infection, including both false negative and false positive tests and delayed test positivity after infection. Thus, the technical capacity of governments and the private sector to prevent transmission of the virus is essentially limited to their ability to provide the general public and special populations with the information and resources necessary to take personal action to limit HIV transmission. Beyond that, they can only attempt to provide necessary and adequate palliative care in the most humane and efficient manner possible.

As was mentioned above, while drugs that can be used to effectively treat penicillin-resistant strains of STDs are available, there is some concern among specialists in the treatment of STDs that new strains of STDs may prove resistant to these drugs, and that fully effective treatment for such possible new strains may not be forthcoming in the near future.

(2) Managerial Constraints - The MOH faces severe managerial constraints in its ability to effectively respond to the looming crises with respect to AIDS and STDs. The principal constraints can be summarized as follows:

- A limited number of adequately trained professional staff at the central level (particularly in the Epidemiology, Sexually Transmitted Diseases, and Health Education Units), which impedes the ability of the MOH to effectively manage a comprehensive AIDS and STD prevention program;

- Field level Contact Investigators are critical for identifying cases of AIDS and other STDs through door to door visits based on information provided by known infected persons. The serious lack of even a minimally adequate number of Contact Investigators is a major impediment to effective control of AIDS and STDs; hiring and training of this type of personnel is a problematic, sensitive, and time-consuming process. (In view of its urgency, this may be an issue that can also be addressed by joint MOH/Administrative Reform Project (ARP) activities which deal with the hiring of GOJ personnel.^{47/});
- Inadequate STD and AIDS surveillance systems without which the MOH cannot effectively plan, evaluate and adjust AIDS and STD programs; and
- Low salary scales, which result in a relatively high turnover of personnel and which are a disincentive to dedicated performance and to maintaining skill levels (through continuing education, for example).

The first three of these constraints are addressed in this Project. The fourth, which is outside the scope of this project, will be the subject of discussions under the ARP.

(3) Resource Constraints - With the few exceptions noted in the previous section, AIDS and STD surveillance, prevention and treatment has been carried out by the Ministry of Health and within previously established MOH budget patterns. There is a severe shortage of resources available for the MOH STD program. The budget for the STD Program cannot be discerned because it is incorporated in the Primary Health Care budget of the MOH, which cannot be disaggregated by Program, only by line item across programs. No additional resources have been provided to the MOH for AIDS activities by the Ministry of Finance in terms of additional resources allocated to responsible MOH units (e.g., the Epidemiology and STD units). The private sector is not currently involved in AIDS/STD surveillance, nor with prevention (with the exception of individual counseling offered by a few private physicians who counsel primarily some middle and upper class homosexual and bisexual men). With the exception of the quasi-public and regional (Caribbean) University Hospital in Kingston, AIDS patients have not been treated through the private sector. A few physicians have diagnosed and provided outpatient symptomatic treatment for middle class and upper middle class persons with AIDS through their private practices. In terms of STDs, reportedly as many as 25% of infected individuals seek treatment through the private sector, but no valid, reliable data are available. Further, only 12-15% of the population in Jamaica has private health insurance coverage, and that coverage with regard to AIDS treatment has yet to be tested. Although some Jamaicans who have worked in the U.S. have health insurance

coverage through which they could receive treatment in the U.S., no data are available regarding the use of these private insurance policies for the treatment of Jamaican AIDS patients, either in the U.S. or in Jamaica.

A lack of key resources has stymied some important AIDS surveillance and prevention activities. For example, no special seroprevalence studies have been conducted since 1986, on-going surveillance has been severely hampered by the dearth of Contact Investigators, and prevention strategies directed toward high-risk groups have not been implemented. Unavailable resources that would have enabled the MOH to undertake these strategies include, for example, central level staff who could plan and implement both surveillance and prevention activities, as well as sufficient funds for local technical assistance, supplies and equipment, and transportation.

Lack of resources has also significantly impeded effective STD surveillance and prevention efforts. A 1986 PAHO report noted important deficiencies in resources available to the STD unit, including inadequate number of staff (particularly Contact Investigators), inadequate training of staff, and lack of critical medical equipment (including microscopes and autoclaves) at the MOH STD clinics. Nearly two years after that report was submitted, the situation has improved little, due to a shortage of funds. Moreover, the urgent need for training of clinic staff to improve the problem of patient flow (noted by another PAHO consultant in 1986^{48/}) has not been met, and there is an added problem of a severe shortage of medications, particularly those to be used in treatment of resistant strains of gonorrhea. The STD program receives only minimal external donor support; for this fiscal year, for example, donor funds for STD activities (not including AIDS activities) totaled only US\$21,600, all of which was provided by PAHO.

The critical shortage of supplies was identified as a problem for the Jamaican health care system in a 1985 USAID-funded study. The supplies for which there were "continuing shortfalls" at MOH facilities included "large volume parenterals (IV fluids)...dressings (gauze, bandages, etc.), gloves, masks and caps."^{49/} In September, 1987, and more recently, these supplies have been identified as in seriously short supply with respect to treatment of AIDS patients specifically. The items in shortest supply include those used for infection control (gowns, gloves, caps, eating utensils, and cleaning equipment), as well as IV fluids used in treatment. At one hospital, there have been complaints by staff that there is a shortage of disposable gloves for use in labor and delivery; while no cause-and-effect relationship with regard to utilization of supplies for AIDS patients has been demonstrated, there is concern about the general lack of available disposable supplies.

Use of condoms is a critical factor in the prevention of AIDS and certain STDs. However, there have been anecdotal reports (by prostitutes and homosexual and bisexual men) of condom breakage. The following may be causal factors in this reported breakage: 1) inappropriate storage at some point in the distribution system (manufacturer to central warehouse to user), 2) strength of condoms can vary by brand, according to recent tests conducted in the U.S.^{50/}, 3) specific sexual practices by homosexual and bisexual men and some prostitutes (i.e., anal intercourse), and 4) improper use of condom (e.g., not allowing space at tip).

The low salary scales for personnel promote an outward migration of physicians and nurses, leaving Jamaica with a relatively low physician and nurse ratio. The physician/population ratio of 2.7/10,000 and nurse ratio of 11.8/10,000 are low in comparison with other Caribbean countries.^{51/} Further, in the recent past, financial constraints have limited the ability of the MOH to hire an adequate number of Contact Investigators for its AIDS and STD programs. At the same time, over-burdened public facilities personnel are not adequately trained to respond to the needs of AIDS patients. However, there are indications that Jamaica's improving economic performance will translate into reduced budgetary stringency.

3. Strategy

a. Overview of Project Strategy

The six-year AIDS/STD Project has been designed to meet the overall Project objective of strengthening the ability of the MOH and the private sector to limit the prevalence of AIDS and STDs in Jamaica during and after the Project. In light of this overall objective, the constraints, and the identified needs, the Project strategy is to: 1) improve information on AIDS and STDs in order to ensure identification of appropriate policies and design of programs for those health problems, 2) implement prevention and intervention activities for AIDS and STDs through strategies directed toward both the general public and specific target populations; and 3) strengthen the capability of the MOH and the private sector to prevent further transmission of AIDS/STDs and thereby to reduce the economic burden of the cost of care.

The strategy of the Project focuses on the critical needs that have been identified by the MOH (principally by the Epidemiology Unit and the STD Unit) and by representatives of the private sector. Selected managerial and resource constraints described previously, which severely hamper the ability of the GOJ to respond to AIDS and STDs, have been directly addressed in the project design. The Project uses existing resources - public and private - to the maximum extent possible, while at the same time

setting the stage for the MOH's pursuit of other sources of donor support. The Project design is directly responsive to the identified objectives of the MOH with regard to AIDS and STDs.

b. Relationship to USAID/Jamaica's Country Development Strategy

The USAID/Jamaica Country Development Strategy Statement (CDSS) approved in April, 1988 includes AIDS and STDs, health care financing, and maternal and child health as the three principal areas of concern in the Jamaican health sector. The CDSS notes the relatively high incidence and prevalence of STDs and their relationship to other health problems including sterility and cancer of the cervix.^{52/} The Mission Strategy related to STDs and AIDS mentions both prevention activities and applied operations research. The CDSS also states that USAID assistance will be provided to both the MOH and local PVOs.

c. Relationship to GOJ National AIDS and STD Plans

The Project is directly responsive to GOJ plans for both AIDS and STDs prevention. The following are the primary objectives from the most recent and relevant MOH documents regarding AIDS and STDs.

The National Plan for AIDS Prevention and Control (Short-term Program, 1988)^{53/} identifies the following objectives:

- To obtain the most accurate and current information possible regarding the incidence and prevalence of AIDS, its natural history in Jamaica, and means of transmission, including risk-group-specific information;
- To decrease sexual transmission of HIV through sustained professional and public education about AIDS and its prevention; and
- To strengthen health service infrastructure to ensure effectiveness in the management of AIDS cases and HIV positive persons.

The STD Control Program Annual Report for 1987^{54/} identifies the MOH objectives with regard to STDs as:

- Development of educational programs and policy guidelines regarding AIDS and STDs;
- Strengthening the STD program through hiring, training and retaining of personnel (including, for example, Contact Investigators), improvements in record-keeping and maintenance of supplies and drugs, and improvements in and at facilities; and

- Strengthening the STD surveillance system, including for example reporting and analysis of data.

d. Current and Potential Donor Support for AIDS and STD Programs

The dearth of resources available to the GOJ to meet these objectives has already been described above. To date, minimal external resources have been provided by donors to assist the GOJ in its AIDS and STD surveillance, prevention and treatment efforts. Specifically, current support for AIDS and STDs strategies includes:

- USAID/Jamaica has provided loans of US\$45,000 to the MOH for the development, reproduction and distribution of posters and brochures and purchase of ELISA screening kits. USAID/Jamaica also provided a grant of US\$100,000 to the JIS in late 1987 for development, production and presentation of television and radio public service announcements. Short-term technical assistance has been provided through AIDSCOM and AIDSTECH in 1988 for final design of a seroprevalence study of HIV among Jamaican prostitutes in Kingston and Montego Bay.
- USAID, through the Family Planning program, has also supported expansion of the coverage and effectiveness of contraceptive delivery systems, which include condom distribution and support for the Family Life Education activities (which in turn include provision of information relating to AIDS and STDs). USAID has also purchased drugs used in the treatment of certain STDs.
- PAHO (the regional office of the World Health Organization), through CAREC, has provided funds for education and training of MOH staff, consultation on laboratory facilities, and Western Blot testing and analysis. An additional PAHO grant is about to be signed for a total of US\$150,000 to continue these sorts of activities.

There are only two other potential sources of support for AIDS and STD programs of which the MOH is relatively certain (other than the subject Project and continued support from PAHO/WHO). The Canadian International Development Agency (CIDA) will provide approximately C\$50,000 sometime in FY 88 for equipment and supplies (to be purchased from any source). In addition, the European Economic Community (EEC) will assign a long-term technical advisor on epidemiologic surveillance by October 1988, and is financing a new central laboratory building, equipment and vehicles that will be used for, among other things, AIDS/STD activities.

B. Goal, Purpose, Inputs and Outputs

The Project Log Frame displays the interrelationships among the Project goal, purpose, inputs, and outputs.

1. Project Goal and Purpose

The goal of the proposed six-year Project is to improve the health status of the Jamaican people. This goal is consistent with the LAC Bureau objective of improved health and health services. The purpose of the Project is to reduce HIV transmission and the incidence and prevalence of STDs in Jamaica. By PACD, the project is expected to achieve:

- 10% reduction in estimated number of HIV seropositive persons (below current est. of 3,000);
- Annual reported cases of congenital syphilis 30 or below (from 36 in 1987);
- Blood donor syphilis seropositivity rate 4% or below (30% below 1987 rate of 6%); and
- Culture-proven gonorrhea rate in under-20 population reduced by 20% from 1988 baseline.

2. Project Inputs

USAID funded Project inputs include:

- Approximately 720 pm of local and expatriate short-term technical assistance and local long-term technical assistance to the MOH and private sector organizations (including PVOs);
- Approximately 4 pm of overseas training and approximately eight local training sessions for personnel engaged in AIDS and STD surveillance and prevention;
- Local costs for Contact Investigators; media campaigns, workshops, and other educational interventions with risk groups and other target populations; operations research and other surveys (e.g., KAP studies);
- Approximately \$366,000 for the procurement of equipment (including medical and office equipment), supplies and critical pharmaceuticals (the latter for use in screening and treating high priority STDs);
- Two vehicles for use in surveillance and prevention activities.

3. Project Outputs

Project Outputs in each of the three components of the Project include:

Policy and Program Planning and Monitoring

- Increased on-going surveillance capacity on the part of the MOH, in terms of both adequacy of staff and improved laboratory capacity;
- Operations research studies periodically conducted among high-risk groups; and
- KAP and other surveys conducted.

Prevention and Intervention

- Eight additional STD clinics equipped and functioning efficiently in existing facilities which already offer a variety of services, including family planning services;
- On-going MOH and private sector media and educational campaigns;
- A National AIDS/STD hotline is operational;
- MOH and private sector conduct prevention activities directed toward high-risk groups;
- On-going education and prevention activities in grades 6-12; and
- MOH and private sector implement prevention strategies directed toward adolescents, women of child-bearing age, lower socio economic groups, high-risk groups for AIDS, and other target populations.

Institutional Strengthening

- Improved capacity of the MOH and private sector to design and implement effective AIDS/STD policies and programs; and
- Increased MOH and PVO capacity to undertake applied operations research (health services research) and evaluation studies and to utilize the results of such research and evaluation in policy and program development.

C. Description of Project Components

The Project has three major components, each of which is designed to meet the Project purpose and contribute to the Project goal in

the most cost-efficient manner possible, given the limited resources available to the MOH and the private sector in Jamaica. The components also are intended to help ensure that the GOJ meets its objectives with regard to prevention of AIDS/STDs. The three components of the Project are:

1. AIDS/STDs Policy and Program Planning and Monitoring;
2. AIDS/STDs Prevention and Intervention Strategies and Activities;
3. Strengthening MOH and Private Sector Capacity to Respond to AIDS/STDs.

The types of activities to be supported in each of these are described below.

1. National AIDS/STD Policy and Program Planning and Monitoring

This component of the Project will ensure that the information needed to formulate appropriate AIDS/STD policies and programs is available. Further, strengthening the AIDS/STD surveillance system and conducting baseline and periodic surveys will assure monitoring of the Project's achievements. Information generated by this component of the Project will be used to design and implement both prevention and treatment activities. Given the nature of the problem, it is an operating assumption that gender disaggregated data is a necessary aspect of the surveillance system as well as the operations research and special studies/surveys. As such, data will be kept both in terms of epidemiologic statistics tracking the progression of AIDS/STDs and also in terms of beneficiary statistics such as gender and age categories.

a. Improvements in the MOH Epidemiologic Surveillance System - (\$27,000)

The MOH AIDS surveillance system will receive support from PAHO/CAREC (in the form of training and technical assistance and of funds for testing equipment and supplies), from the Canadian International Development Agency (in the form of equipment and supplies), and from the EEC (which will provide an Epidemiologist for two years beginning in October, 1988). The epidemiologic surveillance system will be strengthened through the Project in the following ways:

- (i) Purchase of microscopes and other equipment and of testing supplies for the MOH STD clinics. This critical need, identified by PAHO consultants in 1986. Unfortunately, PAHO funding limitations did not allow them to respond and the need has yet to be met. The equipment will be purchased during the first year of the Project; testing supplies will be purchased by the MOH as a GOJ contribution.
- (ii) During the first year of the Project, the MOH STD Unit will

conduct a needs assessment of STD surveillance procedures used by the MOH STD clinics, using the 1986 PAHO reports and other documents as the initial basis for problem identification. The Study will be coordinated by the Project Manager with local and expatriate technical assistance contracted as necessary and appropriate to assist in conduct of the study. The study will provide recommendations for specific improvements in STD surveillance procedures, within the context of the limited resources available to the MOH.

- (iii) Improvements in the STD Surveillance System. Based on the results of the Needs Assessment Study, the SMOH for the STD Unit will design improvements in the existing surveillance system, including, for example: a) changes in reporting formats or procedures; b) training of health providers and clerical staff directly responsible for completing, compiling, tabulating and analyzing STD reports (in the public and private sectors); c) improvements in the flow of information at all levels - from the level of the individual health unit to the central level MOH, including the private sector; and d) improvements in analyzing the information and preparation of reports for use in decision-making at the national, parish, and clinic levels. An important aspect of improvements in the surveillance system, in particular given the reported use of the private sector for treatment of STDs, will be improvements in mechanisms for ensuring compliance on the part of the private sector in reporting STDs, and changes in reportable disease classifications.

The SMOH for the STD Unit and the Operations Research Specialist will work with the SMOH for Epidemiology, with consultation from the EEC Epidemiologist and other advisors as available (e.g., through PAHO, which has provided consultation for the STD Unit in the recent past, and CDC, if available through a centrally funded cooperative agreement.

b. Design and Implementation of Operations Research Studies - (\$181,000)

The MOH has identified the conduct of operations research studies as an important component of its AIDS and STD prevention strategy. The Ministry has initiated a study of the seroprevalence of HIV and other STDs among prostitutes in Kingston and Montego Bay, with A.I.D. centrally-funded technical assistance through AIDSCOM and AIDSTECH. The MOH is currently reviewing the protocol for this study and planning for implementation in late Summer and early Fall, 1988. The conceptual approach of the Ministry is based in "action research"; that is, in the use of data collection procedures and contacts to both retrieve information from and disseminate information to the target populations.

The MOH has identified prostitutes, migrant farm workers (who travel to the U.S), homosexual and bisexual men, and higglers as at particular risk for AIDS, and will initiate seroprevalence studies in these populations during the first year of the Project. The Project will contribute to the support of the MOH Epidemiology Unit's adaptation of the AIDS Seroprevalence Study of Prostitutes for application to other high-risk populations.

Throughout the Project, the MOH will assess its needs for additional (or continuing) studies and will set priorities accordingly. Specifically, the Project will support the following aspects of seroprevalence studies:

- (i) medical staff who are assigned (or hired) to collect data will be trained in interviewing techniques, particularly as regards the risk population members whom they will be interviewing. Conversely, skilled non-medical interviewers will receive training in basic medical information that will enable them to answer questions directly (and to refer some questions to appropriate medical personnel).
- (ii) local and expatriate technical assistance as deemed necessary by the Epidemiology Unit;
- (iii) other local costs (including, for example, payments to interviewers, transportation, and processing and data analysis.

c. Special Studies and Surveys - (\$225,000)

The Project will support updates of the National AIDS/STD KAP study, and baseline and periodic resurveys of STDs to verify surveillance data. The KAP and STD surveys will be contracted through the MOH and carried out by local contractors, with technical assistance as necessary and appropriate through AID/W centrally-funded contracts, including AIDSCOM, CDC, and SOMARC. The AIDS KAP study currently being funded by SOMARC will be expanded to include STD information to enhance the cost effectiveness of use of study funds. The STD survey, developed by CDC, will be implemented during Year 1 of the Project and will serve as the baseline data for STD incidence and prevalence. Periodic resurveys will be supported under the Project.

2. National AIDS/STD Prevention and Intervention Strategies

The MOH will work with the National AIDS Committee, other Ministries, and the private sector to design and implement a variety of strategies that are specific to the needs of the general population and specific target groups in Jamaica. In carrying out these strategies, the MOH will to the extent possible utilize Jamaican organizations that have proven successful in carrying out health and social development projects in Jamaica,

e.g., ACOSTRAD and Operation Friendship. Activities in this Project component will continue throughout the life of Project.

a. Mass Communications and Prevention Strategies Directed Toward the General Public - (\$345,000)

USAID/Jamaica has funded the current mass media campaign and the related KAP study associated with the campaign. This campaign will continue through February 1989. The KAP studies will be used to revise the current campaign, including identification of appropriate messages and vehicles for information dissemination (television, radio, national newspapers, and the JIS' "Good Evening Jamaica" rural multi-media programs). Activities will include continued support for mass communications campaigns directed toward the general public. There will be strong design linkages between this activity and the Targeted Prevention Strategies outlined below, as the media messages will be targetted for mothers, adolescents, potential drug abusers, etc. These campaigns will be coordinated by the local, full time Communications Specialist to be funded under the project (see section 3.a.(iv).). To the extent necessary (or deemed appropriate by the MOH), contracts for design and production of audiovisual and print mass media campaigns will be arranged with public and private sector organizations; short-term local and expatriate technical assistance will be contracted as necessary.

Private sector organizations (including voluntary and for-profit entities) will be encouraged to participate in AIDS/STD prevention efforts; such organizations could include, for example, churches and other religious organizations, the Jamaican Red Cross, community service organizations such as Optimist Clubs, Projects for People, and the Jamaican Agricultural Society. In some cases, small amounts of funding may be provided to non-profit organizations to partially support their AIDS/STDs prevention activities.

The Project will include support for activities such as:

- The production of videotapes that can be used by a variety of public and private agencies and by community-based organizations;
- Production and dissemination of brochures directed toward the general public;
- Production of public service radio and television announcements;
- Production and broadcast of radio programs such as the highly successful Naseberry Street, which reaches a wide audience and carries messages regarding family planning;

- The cost effectiveness of other activities, such as plays by community-based groups, conferences and health fairs, and a national AIDS/STD hotline, will be evaluated for possible inclusion as activities under the Project.

Support for all of these activities will include training of MOH and other ministry staff, and staff of private sector organizations involved in AIDS/STD education/communication; local and/or expatriate technical assistance; and purchase or production of audiovisual and/or printed materials. The GOJ contributions to these activities will include radio and television air time for public service announcements.

b. Targeted Prevention Strategies - (\$465,000)

In addition to prevention campaigns aimed at the general population, the Project will support the development and implementation of prevention strategies directed toward specific target groups, as described below.

- (i) High-risk Groups. The groups that have been identified by the MOH as most at-risk for AIDS in Jamaica include farm workers, prostitutes, homosexual and bisexual men, and informal commercial importers (higglers). As has been described in the section on "Design and Implementation of Operations Research Studies," the MOH will utilize such studies as one mechanism to guide AIDS and STD prevention. Such preventive activities will include provision of informational materials, distribution of condoms, and counseling (individual and group). Specific additional prevention strategies have not been identified, but will be designed to address the needs of each specific population and can include and supplement those identified above for the general public. To the extent possible, members of at-risk populations will be encouraged to participate in AIDS (and STD) prevention through voluntary, anonymous activities that they deem appropriate. This can include, for example, arranging for informal discussions and distribution of condoms and of brochures discussing the importance of safe sex (for those who are likely to have multiple partners). When necessary and appropriate, contracts may be let by ACOSTRAD to individuals or organizations that have access to high risk populations, to facilitate outreach to these populations. (See Section IV.B. Institutional Arrangements.)
- (ii) Maternal and Child Health Prevention. Jamaica has relatively high proportions of female heterosexual and pediatric AIDS (the latter through perinatal transmission),

and the escalating incidence of congenital syphilis makes AIDS and STD prevention among women of child-bearing age a high priority. Maternal and child health AIDS/STD prevention strategies will be coordinated by the Project Manager who will work with the PMO, Epidemiology Unit (to whom he/she will be responsible), the SMOH, STD Unit, and the SMOH, MCH Unit, as well as the SMOH's for the parishes. During the first year of the Project, a determination will be made regarding the appropriateness and feasibility of antenatal testing for AIDS and STDs at MOH clinics. The Communications Specialist will work with the Operations Research Specialist (and the SMOH, STD Unit, and SMOH, Maternal and Child Health) to design educational materials for distribution to women attending the MOH antenatal clinics. Throughout the Project, support will be provided to the MOH for the development and production of materials to be used by health personnel in educating women attending family planning and antenatal clinics. The health personnel at these clinics will also receive training in AIDS and STDs education and counselling.

- (iii) Adolescent AIDS and STDs Prevention Programs. ACOSTRAD, experienced in liaison with the Ministry of Education, will work with the Ministry to develop effective school-based AIDS and STDs education programs. This will include training of personnel (teachers, guidance counselors and school health nurses) and support for development and production of educational materials. It will also include support for reproduction and expanded use of existing STD materials, evaluation, acquisition and/or adaptation of both AIDS and STD materials which have proved successful elsewhere and have been determined to be appropriate for Jamaica.

Not all adolescents can be reached through the school system, and those who can't may be most at-risk for both AIDS and STDs. In recognition of this, ACOSTRAD will work with organizations that reach adolescents through a variety of mechanisms. This will include, for example, the following:

- Funding of AIDS and STD prevention activities through the Family Life Education Series, which has already supported the work of such community-based organizations as Operation Friendship in producing and disseminating AIDS prevention information. This support has been provided by the National Family Planning Board, and involves both the Ministry of Education and the Ministry of Youth and Community Development. Funding will include, for example, publication and distribution of brochures, training of personnel and volunteers involved in AIDS/STD prevention activities, and conduct of community-based educational and outreach activities.

- Funding for AIDS and STD prevention activities directed at organizations that house or provide support for homeless or troubled youth. Financing will support, for example, training of staff and volunteers working with these organizations, and conduct of educational sessions at the homes.

The U.S. National Institute for Child Health and Development and the Office of Substance Abuse Prevention are funding demonstration projects designed to prevent AIDS among such adolescents; the experience of these projects could prove useful for this prevention activity. Importantly, the materials developed through the projects will be in the public domain and can thus be adapted at minimal cost to this Project.

- (iv) Alcohol and Drug Abuse Prevention Activities. Because of the important links that have been established between AIDS and use of alcohol and other drugs (apart from IV drug use transmission), and because of the results of studies of alcohol and drug abuse among Jamaican school students (see Background section), the Project will include activities designed to prevent alcohol and drug abuse, focusing on adolescents, and linking such prevention activities with family planning, AIDS and STD prevention and education. These activities could include, for example:

- Conduct of educational sessions through community-based organizations, service organizations, and at workplaces, health centers, and schools and homes for orphaned or troubled youth (in conjunction with activities described above), and
- Production and distribution of brochures, posters and other audiovisual materials.

Extensive use will be made of pertinent materials being developed in the U.S. under U.S. federal auspices, and of community-based organizations in Jamaica that have experience in working with adolescents and in health education among other populations that may be considered target groups during the course of the Project.

c. Targeted Treatment for STDs - (\$250,000)

Both the prevention strategies directed toward the general public and those directed toward targeted populations will result in increased STD clinic attendees. For example, the mass communication campaigns will include messages designed to encourage those members of the general public who believe that they may have an STD to visit an MOH clinic. Targeted programs such as the Adolescent Prevention programs will be designed to

encourage specific groups to seek diagnostic and/or treatment services at the STD clinics when necessary. Importantly, the operations research study for high risk groups will also result in referrals to the MOH STD clinics.

The Project will ensure that the facilities are in place to adequately deal with this projected increase in the number of persons screened and treated for STDs by:

- (i) Equipping eight additional STD clinics in existing MOH facilities. These additional clinics will enable each of the 14 parishes to have its own STD clinic by the end of the Project. The 15 Contact Investigators hired and trained over the life of the Project will staff the clinics (see 3.a.(i) below), and the STD laboratory equipment and supplies will be provided by the Project to accomplish this (see 1.a.(i) above).
- (ii) STD Pharmaceuticals. The MOH experiences ongoing shortfalls in the provision of essential drugs for all categories of illnesses, including STDs. Since it is unlikely that the Project will succeed in reducing the incidence and prevalence of STDs without needed treatment, this issue must be addressed. An initial activity of the Project will be technical assistance to analyze the shortfall of essential STD pharmaceuticals; provide recommendations to maximize utilization of what is available; and recommendations to USAID on financing of pharmaceuticals to treat targeted STDs. In line with the Project Agreement Covenant, the proportion of the identified need being funded by the the GOJ's contribution will be increased over the live of the Project.

The STD Unit will be responsible each year for identifying the need for specific pharmaceuticals to treat high priority STDs based on STD clinic attendance, contact investigation results, and analysis of data from the prior year, including an estimate of the potential impact of education programs that could increase clinic attendance and thus increase the demand for STD drugs.

3. Strengthening the Institutional Capability of the MOH and the Private Sector to Manage Comprehensive AIDS/STD Strategies

This component of the Project is designed to enhance the capability of both the Ministry of Health and the private sector to design, implement and manage national-level AIDS and STD strategies.

a. Institutional Strengthening of the MOH - (\$780,000)

The MOH has the primary responsibility for surveillance and prevention of AIDS and STDs in Jamaica. These responsibilities

include development of policies and programs, conduct of on-going and point-in-time seroprevalence studies, contact tracing of infected individuals, design and implementation of prevention strategies, and liaison with those responsible for treatment of AIDS and STD patients. Support for MOH activities in AIDS and STD surveillance and prevention activities include:

- (i) Training and salaries of Contact Investigators to be hired on contract by the MOH. During Year 1 of the Project, funds will be provided to contract for the services of 5 Contact Investigators, three of whom will be assigned to the Comprehensive STD Clinic in Kingston, and two to St. James Parish, the areas of highest concentration of STDs. They will also serve other parishes as necessary to increase surveillance capacity in rural areas. During Years 2 and 3, the Project will contract for five additional Contact Investigators (for a total of ten the second year and 15 the third year). They will be assigned by the STD Unit to other parishes as deemed necessary at that time, contingent on trends in AIDS and STDs and resources available at each parish. After the third year of the Project, the MOH will assume financial responsibility for the Contact Investigators on a phased basis (i.e., five in Year 4, ten in Year 5, and all fifteen in the final year of the project).

Training will be provided through the Project for all current Contact Investigators and for all those hired during the course of the Project. The training program which will be coordinated by the STD Unit utilizing local and expatriate technical assistance as needed will encompass:

- Design and implementation of intensive training that will reduce the amount of time necessary to place newly hired Contact Investigators in the field from two years to three months;
 - Design of a Continuing Education training program that will be used to ensure the competency of existing and newly hired Contact Investigators; and
 - Short-term training in the U.S. in community epidemiology and in AIDS and STDs, for two Contact Investigators during Year 1. The training will be configured to ensure that initial trainees are capable of training additional Contact Investigators.
- (ii) Training of MOH staff. The Project will train public and private health sector personnel in AIDS/STD surveillance, prevention and intervention (including counseling). With technical assistance from AIDSCOM and AIDSTECH, training of

trainers packages will be developed for each topic area. Given the important role played by women in the health sector as nurses, doctors, and other health care providers, steps will be taken to ensure that women are adequately represented among the trainees. Training programs to be supported include:

- (a) Training in appropriate infection control techniques will be provided for hospital and clinic staff.
- (b) Training in program planning and management, including the use of microcomputers and related software for program management, data analysis, etc.,
- (c) Other topic areas include, but are not limited to counselling, IE&C, and surveillance.

The initial training will be evaluated, and training packages will be developed or modified for use by MOH staff and volunteers in subsequent training of new personnel as well as training of additional public and private sector personnel as necessary for successful completion of the project.

- (iii) Commodity support. This includes purchase of two vehicles which will be used primarily in the surveillance of AIDS and STDs, but which will be used in other AIDS/STD prevention/intervention activities as deemed appropriate. One vehicle will be assigned to the Epidemiology Unit, and one to the STD Unit.

In order to ensure that the MOH has the necessary computer support for use in collection and analysis of evaluation data and information, during the first six months of the Project, funds will be allocated for purchase of a microcomputer, peripherals, and software and necessary training of MOH staff in the use of software packages for word processing and data analysis. This equipment will be assigned to the Epidemiology Unit of the MOH, but will also be available for use by the STD Unit to supplement their own computer equipment. It will be an important tool for both Units in carrying out their responsibilities for data collection and analysis at the parish, community and local activity level.

Throughout the Project, funds will be provided to the MOH to purchase reference materials and current articles for use in planning, adjusting and evaluating AIDS/STD policies and programs.

- (iv) Support for the contracts of the Operations Research Specialist and the Communications Specialist during the

Years 2-6 of the Project (note AIDSCOM will be funding their contracts during Year 1). These individuals will be hired locally through AIDSCOM and will be assigned to the Epidemiology Unit, and will carry out activities related to both AIDS and STDs.

b. Support for Institutional Development of ACOSTRAD and the National AIDS Committee - (\$60,000)

Both ACOSTRAD and the National AIDS Committee will play critical roles in the development of national AIDS policies and programs, in particular by serving as a forum for public and private sector liaison regarding AIDS. ACOSTRAD will also continue its important role in prevention of STDs. Its primary role under the project will be in the areas of Targeted Prevention Strategies. It will build on its previous experience with both public and private organizations in the design and development of media interventions and the provision of resource personnel.

The Project will provide support to the organizations in several ways, including:

- (i) providing funds for local technical assistance to strengthen the management of ACOSTRAD and the National AIDS Committee; this will enable both of these organizations to be conduits for organizational and individual donor support of AIDS activities in Jamaica. An important organizational objective of ACOSTRAD during the first year of the Project will be to develop additional sources of funding, from sources within and outside of Jamaica. This will help ensure continued support after the end of the Project.

The National AIDS Committee is a newly established organization which will coordinate all AIDS policies and prevention activities in Jamaica. During the first year of the Project, the MOH and USAID will review its activities and achievements in order to determine what type and amounts of support to the National AIDS Committee are appropriate under the Project. The National AIDS Committee Fund-raising Sub-committee, during that time, will explore other funding possibilities;

- (ii) funding for contracts of a Manager, Accountant, and a Secretary for ACOSTRAD for the first two years of the Project;
- (iii) training of ACOSTRAD (and National AIDS Committee staff or volunteers, as appropriate) in AIDS/STD prevention activities and policy and program planning. Training of these staff will be incorporated into MOH training described in 3.(a)(ii) above as appropriate; and
- (iv) commodity support in the provision of a photocopier and a micro-computer.

II. COST ESTIMATES AND FINANCIAL PLAN

The total cost of the six-year AIDS/STD Project is estimated to be US\$3,350,000. Of this amount, A.I.D. is expected to contribute resources totalling US\$2,500,00, while the equivalent of US\$850,000 will be contributed by the GOJ. First year obligations in FY 1988 are expected to be \$540,000. Contingency has been estimated at 5% of Project costs each year, and compounded annual inflation factors of 10% for local costs and 5% for U.S. costs have been included in years 2-6 of the Project.

A. Summary Cost Estimate and Financial Plan

Table I presents a summary of the cost estimates and financial plan for the 6-year project. The GOJ is contributing 25% of Project costs with increasing fiscal responsibility toward the end of the Project. The GOJ contribution will include Administrative Support (the Project Manager and support staff), clinic supplies, pharmaceuticals and Contact Investigators (these latter two with an increasing share). USAID will finance long and short term Jamaican TA, short term US TA, commodities, training, and local costs. Maximum possible use will be made of centrally-funded AID/W resources, including for example AIDSCOM, AIDSTECH and SOMARC. These mechanisms will be used where practical and cost-efficient for securing short-term technical assistance and equipment and supplies.

B. Costing of Project Outputs/Inputs

Table II shows costing of Project inputs and outputs.

C. Projection of Expenditures by Fiscal Year

Table III shows the estimated expenditures by component by year.

D. Methods of Implementation and Financing

Table IV shows the basic methods of financing and implementation for the USAID funded activities of the AIDS/STD Project. USAID will provide funds to the MOH on a reimbursement basis. The MOH has been found to have the necessary procurement procedures, contracting and financing capability and has performed competently in those areas in previous projects which received USAID funds. The Controller's Office conducted a follow-up review of their financial procedures on August 3, 1988 and found them adequate.

TABLE I - Summary Cost Estimate and Financial Plan

OUTPUTS	INPUTS	----AID-----			GOJ LC	--TOTAL--	
		FX	LC	Total		FX	LC
Administrative Support	J staff	0	0	0	125	0	125
Evaluations & Audits	ST TA	40	8	48	0	40	8
1. POLICY & PROGRAM PLANNING & MONITORING							
MOH/Epi Surveillance Sys.	Equip./supplies	2	25	27	180	2	205
Operations Research	ST TA	46	0	46	0	46	0
	Local Costs	10	125	135	0	10	125
Special Studies & Surveys	ST TA	15	0	15	0	15	0
	Local Costs	0	210	210	0	0	210
SUBTOTAL		73	360	433	180	73	540
2. PREVENTION AND INTERVENTION STRATEGIES							
Mass Media Campaign	Local Costs	0	345	345	0	0	345
Targeted Prevention	ST TA	53	52	105	0	53	52
	Local Costs	0	360	360	0	0	360
Targeted Treatment - STDs	Pharmaceutical	250	0	250	350	250	350
SUBTOTAL		303	757	1060	350	303	1107
3. INSTITUTIONAL STRENGTHENING							
Public Sec. Strengthening	Contact Invest.	0	180	180	142	0	322
	CI J training	10	13	23	0	10	13
	CI US training	11	0	11	0	11	0
	MOH J training	2	40	42	0	2	40
	Commodities	20	36	56	0	20	36
	Vehicles/O&M	0	24	24	13	0	37
	LT Specialists	0	444	444	0	0	444
Priv. Sec. Mgmt. Strength.	ST TA	0	10	10	0	0	10
	Commodities	0	15	15	0	0	15
	J Consultants	0	35	35	0	0	35
SUBTOTAL		43	797	840	155	43	952
TOTAL		459	1922	2381	810	459	2732
Contingency		23	96	119	40	23	136
GRAND TOTAL		482	2018	2500	850	482	2868

TABLE II - Costing of Project Outputs/Inputs

	Long Term J TA	Short Term US TA	Short Term J TA	Over- seas Commod.	Local Commod.	Over- seas Trng.	Local Trng.	Local Costs USAID	USAID SUBTOT.	Local Costs GOJ	TOTAL
Administrative Support										125	125
Evaluations & Audits		40	8						48		48
1. POLICY/PROGRAM PLANNING/MONITORING											
MOH/Epi Surveillance System					27				27	180	207
Operations Research Studies		46						135	181		181
Special Studies & Surveys		15						210	225		225
2. PREVENTION/INTERVENTION STRATEGIES											
Mass Media Campaign								345	345		345
Targeted Prevention		53	52					360	465		465
Targeted Treatment of STDs				250					250	350	600
3. INSTITUTIONAL STRENGTHENING											
Contact Investigators	180					11	23		214	142	356
Trained hospital/clinic staff							42		42		42
Commodity Support				20	36				56		56
Vehicles/O&M					24				24	13	37
Specialists	444								444		444
Private Sector Mgmt. Strength.			10						10		10
Commodity Support					15				15		15
ACOSTRAD staff	35								35		35
TOTAL	659	154	70	270	102	11	65	1050	2381	810	3191
Contingency	33	8	4	13	5	1	3	52	119	40	159
GRAND TOTAL	692	162	74	283	107	12	68	1102	2500	850	3350

TABLE III - Projection of Expenditures by Fiscal Year

COMPONENT	--FY89--		--FY90--		--FY91--		--FY92--		--FY93--		--FY94--		--TOTAL--	
	AID	GOJ	AID	GOJ										
Administrative Support		17		18		20		22		23		25	0	125
Evaluations & Audits	0		0		0		25		0		20		48	0
1. POLICY & PROGRAM PLANNING & MONITORING														
MOR/Epi Surveillance System	27	30	0	30	0	30	0	30	0	30	0	30	27	180
Operations Research Studies	35		36		28		32		25		25		181	0
Special Studies & Surveys	50		25		40		30		50		30		225	0
SUBTOTAL													433	180
2. PREVENTION AND INTERVENTION STRATEGIES														
Mass Media Campaign	70		70		70		45		45		45		345	0
Targeted Prevention	65		76		67		88		74		75		465	0
Targeted Treatment of STDs	100	0	70	30	50	50	30	70	0	100	0	100	250	350
SUBTOTAL													1060	350
3. INSTITUTIONAL STRENGTHENING														
Contact Investigators	24	0	56	0	68	0	43	22	23	46	0	74	214	142
Trained hospital/clinic staff	7		8		8		9		10		0		42	0
Commodity Support	30		4		4		4		10		4		56	0
Vehicles/O&M	24	2	0	2	0	2	0	2	0	2	0	3	24	13
Specialists	0		73		80		88		97		106		444	0
Private Sector Mgmt. Strength.	5		5		0		0		0		0		10	0
Commodity Support	15		0		0		0		0		0		15	0
ACOSTRAD staff	17		18		0		0		0		0		35	0
SUBTOTAL													840	155
TOTAL	469	49	441	80	435	102	397	146	334	201	305	232	2381	810
Contingency	23	2	22	4	22	5	20	7	17	10	15	12	119	40
GRAND TOTAL	492	51	463	84	457	107	417	153	351	211	320	244	2500	850

The methods of financing do not deviate from AID's preferred methods. The implementing agency, the MOH, will contract for all goods and services provided by the grant except for buy-in arrangements (e.g. with AIDSTECH and AIDSCOM), direct contracts for audits and private sector management strengthening, pharmaceuticals procured through GSA, and overseas training.

A sub-grant will be provided to ACOSTRAD, which has indirectly received USAID funding (through the Family Planning Project). A review of ACOSTRAD's procedures for accounting and fiscal reporting will be conducted by a Chartered Accountant (CPA) prior to signing of the sub grant in order to assess the organization's overall competency in those areas. The firm will put in place their suggested changes. In addition, the Regional Contracts Officer will conduct a a review of ACOSTRAD's contracting procedures. Guidance and training will be provided based on the results of these reviews followed by follow-up evaluations over the course of the year following sub-grant signing. During the six-year Project, the Mission will ensure compliance with AID's reporting standards and will verify that separate accounts are maintained to facilitate reporting and adequate audit trails.

Table IV - Methods of Implementation and Financing

Input	Method of Implementation	Financing	Amount
--Local TA	AID Direct (audit)	Direct Payment	18
--US & Local TA	AID Direct (Buy-in)	Direct Payment	650
--Local TA	HC Contract	Reimbursement	180
--Local Training	AID Direct (Buy-in)	Direct Payment	20
	HC Contract	Reimbursement	45
--Overseas Trng.	PIO/P	Transfer of Funds	11
--Overseas Commod.	HC Procurement (PSA)	LComm/Bank LComm	20
--Overseas Commod.	GSA	Direct Payment	250
--Local Commod.	HC Procurement	Reimbursement	87
--Local Costs	HC Procurement	Reimbursement	694
--Local TA	Sub-grant	Advance/Reimbursement	35
--Local Commod.	Sub-grant	Advance/Reimbursement	15
--Local Costs	Sub-grant	Advance/Reimbursement	356
Contingency			119
TOTAL			2,500

IV. IMPLEMENTATION PLAN

A. Implementation of Project Components

Initially, the Project will focus on supporting the MOH in its efforts to immediately respond to the worldwide AIDS epidemic and the STD epidemic in Jamaica, including initial strengthening of institutional capability. Subsequently, the focus will be on further strengthening of the capability of the MOH (and the private sector) to design and implement prevention activities relating to AIDS and STDs, while continuing surveillance and preventive activities.

The Implementation Schedule in Table V presents the six-year plan of activities and responsible parties for the Project outlined in Section II.C. Necessarily, only minimal detail can be provided for activities in the out years of the Project, as these activities are largely contingent upon the relative success of surveillance and prevention activities undertaken during the earlier years of the Project, as well as on changes in the worldwide AIDS epidemic and in medical technologies available to prevent and treat this disease as well as STDs.

B. Institutional Arrangements

1. Grantee's Institutional Arrangements

Funds will be obligated through a bilateral grant agreement with the Ministry of Health, with a sub-grant to ACOSTRAD. Financing will be provided for a portion of Project coordination and support costs for each of these entities, as well as support for specific activities to be undertaken by each organization.

The Project will be carried out through the following arrangements:

- Host country contracts and sub-agreements to Jamaican public, quasi-public and private sector organizations for specific Project activities, including for example, development and dissemination of mass media campaigns and design and implementation of targeted prevention activities.
- Buy-in arrangements for short-term technical assistance and training through projects such as AIDSCOM and AIDSTECH;
- Host country and direct contracts for short-term technical assistance and training;
- Work orders under AID/W centrally-coordinated IQCs for technical assistance and training.

Implementation of the direct grant to the MOH is summarized below:

(a) A Project Implementation Unit (PIU) will be set up within the Epidemiology Unit. The PIU will also support activities of the STD Unit (and other units as appropriate). An MOH Project Coordinating Committee (PCC) will also be established. The Project would support:

-- Contracts for services of: (1) a full time Project Manager (who will be responsible for day-to-day administrative matters, including for example preparing financial and managerial quarterly reports to USAID, documentation necessary for purchase of commodities, contracting of technical assistance including Requests for Proposals and Scopes of Work, and monitoring of sub-grants and contracts); (2) an accountant; and (3) a full time secretary (who will report to the Project Manager), each of whom is to be hired for and assigned to the Project Implementation Unit;

-- Contracts for services of the Operations Research Specialist and Communications Specialist, each of whom would be contracted through AIDSCOM (and assigned to the Epidemiology Unit);

-- Contracts for services of 15 additional Contact Investigators (5 for the first year, 10 for the second year, and 15 for the third year of the Project), to be assigned to the STD Unit;

-- Office equipment and supplies (e.g., microcomputer, photocopier, etc.) and medical equipment (i.e., microscopes and supplies for the STD clinics - AIDS equipment being purchased primarily through other donor agencies).

-- Certain other policy and program evaluation activities and direct surveillance activities would also be conducted by or pass through the MOH.

(b) The MOH will enter into a Sub-grant Agreement directly with ACOSTRAD, as an organization with a history of AIDS and STD prevention. ACOSTRAD would undertake education and prevention activities and also would serve as a mechanism for awarding contracts for various preventive activities (see Project Description for examples).

(c) Depending on progress made by the National AIDS Committee in line with its stated purpose as the policy and programming national coordinator for AIDS, the MOH will consider entering into a sub-grant arrangement with the National AIDS Committee, or provide technical assistance to the Committee through

project-funded MOH contract arrangements with other parties. The Committee could conduct (directly or through sub-contracts) selected policy studies or activities.

The Project Coordinating Committee (PCC) will meet at a minimum every three months to review the quarterly report to USAID, which will have been prepared by the MOH Project Manager (who will also attend all PCC meetings). The PCC will provide advice on the general direction of the Project (including discussion of progress and barriers to implementation of Project activities), consider the implications of Project findings for MOH policies and programs, and provide for regular policy dialogue between the MOH, USAID, and the private sector (the latter through the Chairman of the National AIDS Committee). The PCC will include the following members:

- MOH Permanent Secretary
- Chief Medical Officer
- PMO, Epidemiology Unit (Chairman of the PCC)
- SMOH, STD Unit (Co-chairman of the PCC)
- SMOH, MCH
- USAID Project Officer (ex officio)
- Representative of ACOSTRAD
- Chairman or other representative of the National AIDS Committee
- Others to be identified by the MOH

2. USAID/Kingston Organizational Responsibilities

The implementation responsibility within USAID will be held by the Office of Health, Nutrition and Population (OHNP). The USAID Project Officer will be assisted in these duties by a FSN, who will be responsible for preparing all earmarking and committing documentation, drafting all Project-related correspondence, preparing quarterly and semi-annual reports, and making all arrangements for foreign technical assistance and training. The USAID Project Officer will be an ex-officio member of the Ministry's PCC. USAID will also review and approve all contracts and sub-grant proposals submitted for funding. Additional Mission support will be provided by other USAID offices as appropriate (i.e., to include Office of Project Development and Support, Office of Private Sector Development, Office of Contract Management, and Office of the Controller).

In the case of the sub-grant(s) and contracts, the MOH Project Manager, with assistance from USAID/Jamaica, will prepare necessary documentation for approval by USAID and relevant GOJ agencies. In general, the simplest, most expeditious and most cost-efficient form of committing mechanisms and documentation will be utilized. The specific committing document to be used will depend on the activity being funded, and may include a PIO/T, PIO/P, PIO/C, Project Implementation Letter, sub-grant Agreement, contract, or travel authorization.

TABLE V - Implementation Schedule

The various project activities are indicated below on a fiscal year quarterly basis. The following abbreviations have been used to indicate responsible entities for the various activities outlined in the implementation schedule:

A: ACOSTRAD Epi: Head of MOH/Epidemiological Unit CS: Communication Specialist
 ORS: Operations Research Specialist PM: Project Manager STD: Head of MOH/STD Unit

ACTIVITY	WHO	88 Q4	----FY89---				----FY90---				----FY91---				----FY92---				----FY93---				----FY94---			
			Q1	Q2	Q3	Q4																				
ProAg signed	AID/MOH	Q4																								
Conditions Precedent met	MOH	Q4																								
PM & Support staff hired	Epi		Q1																							
ACOSTRAD Subgrant signed	MOH/PM			Q2																						
Mid point evaluation	AID													Q1												
Final evaluation	AID																						Q1			
PACD																										Q4
1. POLICY & PROGRAM PLANNING & MONITORING																										
(a) MOH Epidemiologic Surveillance System																										
MOH/STD Equipment/supplies																										
--specifications provided	STD	Q4				Q4				Q4				Q1				Q4				Q1				Q2
--procurement documents prepared	PM		Q1				Q1				Q1				Q1				Q1				Q1			
--equipment received				Q2				Q2				Q2				Q2				Q2				Q2		
Needs Assessment - procedures	ORS				Q3																					
(b) Operations Research Studies																										
Design	ORS		Q1	Q2	Q3	Q4																				
Implementation	ORS		Q1	Q2	Q3	Q4																				
(c) Special Studies and Surveys																										
General public AIDS/STD KAP study updates ^{2/}																										
--Data Collection	PM							Q2																		
--Analysis	PM								Q4																	
STD Baseline Survey	PM		Q1																							
STD Resurveys	PM									Q1								Q1								
2. PREVENTION AND INTERVENTION STRATEGIES																										
(a) Prevention - General Public																										
Mass Media Campaign																										
--SOW	CS & A		Q1				Q1				Q1				Q1				Q1				Q1			
--contract	CS & A			Q2				Q2				Q2				Q2				Q2				Q2		
--revised and expanded campaign	CS & A			Q2	Q3	Q4	Q1	Q2	Q3	Q4																
(b) Prevention - Targetted																										
--high risk/other target groups	CS & A			Q2	Q3	Q4	Q1	Q2	Q3	Q4																
--MCH - educational materials for MOH antenatal clinics	CS & A			Q2	Q3	Q4	Q1	Q2	Q3	Q4																
--Adolescents - ed. materials	CS & A			Q2	Q3	Q4	Q1	Q2	Q3	Q4																
--Substance Abusers - ed. mat.	CS & A			Q2	Q3	Q4	Q1	Q2	Q3	Q4																

B. Implementation Schedule - (continued)

(c) Targeted Treatment for STDs

Establishment of 8 Clinics	STD							Q3			Q3							
Provision of Pharmaceuticals																		
--assessment of shortfall	STD	Q4			Q4													
--procurement docs. prepared	STD		Q1			Q1												
--Pharmaceuticals available				Q3														

3. INSTITUTIONAL STRENGTHENING

(a) Institutional Strengthening of the MOH

(i) ADDITIONAL CONTACT INVESTIGATORS

5 new contact investigators	STD																	
--hired			Q1															
--training completed				Q2														
5 new contact investigators	STD																	
--hired					Q1													
--training completed						Q2												
5 new contact investigators	STD																	
--hired										Q1								
--training completed											Q2							
TRAINING - Contact Investigators																		
Ongoing STD CI training	STD				Q4													
Training of trainers-overseas						Q2	Q3		Q4									
(ii) TRAINING - hospital & clinic staff	Epi		Q2			Q2				Q2			Q2			Q2		Q2
TRAINING - Central staff/MOH	PM								Q1					Q2				
(iii) COMMODITIES AND VEHICLES																		
--documents prepared	PM		Q1															
--commodities received	PM			Q3														
--computer training	PM				Q4													
Reference materials/periodicals	PM		Q1	Q2	Q3	Q4												
(iv) SPECIALISTS																		
ORS hired ^{1/}	Epi		Q1															
CShired ^{1/}	Epi		Q1															

(b) Strengthening the Capability of ACOSTRAD, the National AIDS Committee, & Other Private Sector Groups

ACOSTRAD staff hired																		
ACOSTRAD registered as a PVO																		
Determination to support National AIDS Committee	PM/AID			Q3														
Management strengthening			Q1	Q2	Q3	Q4												
Training - PVOs & Private Sector			Q1	Q2	Q3	Q4												

^{1/} Both the Operations Research Specialist and the Communications Specialist will be supported by AIDS/Com during Yr 1
^{2/} The first year's study will be supported by SOMARC

C. Training Plan

In-country, and to a limited extent overseas, training of public and private sector personnel will be an important activity of the Project throughout its duration. During Year 1 of the Project, the MOH (working through AIDSCOM, AIDSTECH and other sources of technical assistance) will coordinate the design of training-of-trainer packages for specific topic areas (e.g., AIDS infection control, contact investigation methods, counseling of persons with AIDS and STDs) that can be used with minimal expatriate technical assistance. USAID funds will support training of physicians, nurses, contact tracers, social workers and counselors in AIDS and STDs prevention, treatment, and counseling.

In general, local training capability will be used to the maximum extent possible. Training materials will be packaged to allow for their use in subsequent training of hospital and clinic personnel by those who had been trained initially. A KAP evaluation design will be developed and used to revise the training as necessary to assess and encourage use in practice of the information provided.

Training design throughout the Project will be coordinated with the MOH Master Training Plan and, to the maximum extent possible, utilize available training packages (videos, training manuals, etc.) being developed for US health care providers through Department of Health and Human Service contracts. The latter will be in the public domain and can thus be adapted and used at minimal cost to this Project. Also to the maximum extent possible, training will be carried out through in-country workshops.

Training, to be carried out throughout the course of the Project, will be supported by the Project through provision of local technical assistance and photo-reproduction of training materials.

The anticipated number of individuals to be trained during the course of the 6-year Project is:

- Local, short-term direct training of a total of 500 (400 MOH and 100 private sector) health personnel in surveillance, prevention and intervention (including counseling) related to AIDS and STDs;
- Indirect training (through training-of-trainers activities) of approximately 1,500 additional health personnel and others involved in AIDS and STDs prevention strategies;
- Foreign short-term training of 4 MOH personnel in epidemiology, contact investigation, and counseling related to AIDS and STDs;

- Local, short-term training of 10 MOH and ACOSTRAD personnel in use of microcomputers and word processing, data analysis and program planning and management software,
- Local, short-term training of 25 MOH personnel in design and management of health services research and policy and program planning and evaluation.

The MOH will coordinate with the National AIDS Committee and ACOSTRAD in identifying candidates for participation in training. The MOH will carry out evaluations of training and will make special efforts to ensure that personnel at the parish and local facility level as well as at the central level receive adequate training.

Prior to disbursement of any funds for training under the Project, the MOH Project Director will submit a training plan that will include:

- A detailed overview of overseas and in-country training by year for the first two years, with general training targets outlined for the remainder of the project. This will be revised and updated on an annual basis and will include:
 - 1) a list of the types of candidates to be selected (e.g., Contact Investigators, nurses working with AIDS patients), and names of such individuals if available,
 - 2) a description of the content, duration, and cost of local training, including identification of need and alternative sources for technical assistance for such training, and
 - 3) locations of short-term overseas training, with details regarding content of training, cost, duration, and entrance or advance study requirements for participants.
- Criteria for selection of participants in both in-country and overseas training.

D. Procurement Plan

During the first three months of the Project, the MOH Project Manager (with assistance from USAID and MOH staff as necessary) will prepare documentation (in line with A.I.D. Handbooks 1B and 11) for purchase of the following commodities:

- Two vehicles (one right-hand drive station wagon and one right-hand drive four-wheel drive vehicle;
- Microcomputer equipment and software;
- Two table-top photocopiers;

- Laboratory equipment, e.g., microscopes, incubators, dark field condensers, and
- Information, Education and Communication (IE&C) equipment and supplies.

The majority of the commodities for the MOH (the two vehicles, the computer equipment and software, the table-top photocopier, the laboratory equipment, and the IE&C equipment and supplies) will be procured locally by the MOH Project Manager using competitive procedures for off the shelf procurement as outlined in Handbook 1B. Given the limited amount of commodities to be procured and the need to expedite the procurement process, all of these locally procured commodities will be procured directly by the MOH rather than through the GOJ Supply Division at the Ministry of Finance.

Procurement of pharmaceuticals for the STD program will be based upon annual assessments of the shortfall in STD drugs. In accordance with A.I.D. policy, USAID financed pharmaceuticals will be procured by A.I.D./Washington using the General Services Administration or other centrally designated procurement agent on the basis of PIO/Cs prepared by the USAID Project Office. The MOH Project Manager and the STD Unit will coordinate development of STD drug procurement requests on an annual basis. Over the life of the Project, the costs of the STD pharmaceuticals will be phased into the GOJ counterpart budget for the Project.

Outside of the portion of funds for additional equipment or replacements in Year 5 of the Project, the additional funds made available for commodity procurement in the remaining years of the Project will be used primarily for books, periodicals, current articles, and other reference materials for use by the MOH. A list of these reference materials will be compiled on an annual basis by the Project Manager and procured through the services of a PSA. Efforts will be made to identify an appropriate Gray Amendment firm for this role.

The commodities for ACOSTRAD (the computer equipment and software, and the table-top photocopier) will be procured locally by the ACOSTRAD Project Manager using competitive procedures for off the shelf procurement.

V. MONITORING PLAN

Monitoring of the Project will be carried out by both the MOH and USAID/Jamaica in order to (a) determine if the inputs are being provided in a timely manner, (b) determine the extent to which planned outputs are being achieved, and (c) take timely corrective action when necessary. Project personnel (and other members of the PCC such as the National AIDS Committee representative) will periodically meet with other donors to ensure coordination of efforts.

In terms of USAID/Jamaica's monitoring arrangements, the Project Officer will be the Health and Family Planning Officer. Annually, the Project Officer, assisted by a FSN, will compile and summarize quarterly financial and managerial reports from the MOH and ACOSTRAD, and status reports from AIDSCOM and AIDSTECH.

Additionally, the USAID Project Committee will conduct regular assessments of Project progress through the Mission's Semi-annual Review process. Project progress will also be monitored through the close collaboration of the Project Officer and the Controller's Office.

VI. PROJECT ANALYSES

A. Technical Analysis

The technical analysis examines the feasibility of the Project implementation with respect to the suitability, cost-effectiveness and social profitability of the major actions taken to achieve its goal, purpose and outputs.

A number of alternative approaches to addressing the AIDS/STD problem in Jamaica have been considered for the Project. These include mandatory testing, AZT treatment for AIDS, and not undertaking any prevention or surveillance activities. The conclusion of the technical analysis is that these alternatives, after examination, are not feasible alternatives given considerations of cost, ethical issues, and potential effectiveness in addressing the problem.

Accordingly the surveillance and prevention activities of the Project are found to be the most suitable and cost-effective interventions available.

B. Financial and Economic Analysis

As a result of devaluation of the Jamaican currency and inflation, the effective purchasing power of the MOH has declined by approximately 30 percent since 1980. This has had a negative impact on both the quality and quantity of health services delivered in Jamaican public facilities. The Project, with a focus on AIDS and STDs surveillance and prevention as twin strategies, has the potential to significantly reduce the financial burden of AIDS and STDs on the MOH, and on individuals and families of those who are at-risk.

An analysis of the potential for financial benefit of this Project, considering only the cost of treatment (see Annex F), shows the potential for a savings in treatment costs (by 1993) of J\$6.8 million for AIDS, nearly J\$2 million for gonorrhoea, approximately J\$600,000 for syphilis, nearly J\$100,000 for congenital syphilis, and nearly J\$34 million for severe pelvic inflammatory disease in women. Thus, the total Project expenditure of J\$18.2 million (US\$3.3 million) will be more than offset by a savings in AIDS/STD treatment costs of J\$43.3 million (US\$8.2 million), given a relatively low estimate of the impact of improved surveillance and prevention activities.

The MOH contribution to the Project is less than one percent of the 1986/87 MOH budget and is allocated for expenditures that should be included in recurrent MOH budget allocations. With the exception of salaries of Contract Investigators and the supply of

STD pharmaceuticals, substantial recurrent costs following PACD would be limited. This contribution is not considered out of line with the financial ability of the GOJ to support human infrastructure services, particularly since the most recent economic performances suggest that economic improvement will continue.

The Project will strengthen ACOSTRAD in its capability to generate alternative donor support, both within and external to Jamaica.

A detailed review of the economic benefits of the Project has not been carried out as the Project benefits are extremely difficult to quantify in economic terms. However, it is felt that the large financial benefits would translate into equally large economic benefits.

C. Social Soundness Analysis

Prevention of AIDS and STDs is at the core of this Project. The medical and socio-cultural complexity of AIDS renders it exceedingly difficult to design effective AIDS prevention efforts. Resource constraints compound the problem in developing countries such as Jamaica. STD prevention, although for the most part technically feasible, has proved costly, time-consuming and problematic and requires long-term, ongoing efforts.

The target population for AIDS prevention, as defined by the World Health Organization, the U.S. Public Health Service, and the GOJ, is the general population. For Jamaica, in addition to the general population (of 2.3 million in 1987), the groups which have been defined as most at-risk -- with estimated numbers of each -- are prostitutes (1,000), migrant farm workers (10,000), higglers (2,000), men engaging in regular or occasional homosexual practice (11,000), and the sexual partners of these individuals. For purposes of this Project, women of child-bearing age and adolescents are also defined as important target populations, the former because of the high rate of pediatric cases of AIDS in Jamaica thus far, and the latter because of the high rates of STDs in the age group for the past several years. Further, a particular focus of the targeted prevention activities with regard to both AIDS and STDs will be identifying means of access to lower socio-economic groups, particularly those with less access to MOH and private health care facilities, and those who are illiterate.

The AIDS epidemic has raised issues that most members of the general public - and health professionals - would rather not face. These include the prevalence of and societal reactions to sexual practices which place the persons involved at relatively high risk for AIDS, fear of so-called "dread diseases" (which until recently in the U.S. included cancer), and fear of death and dying. In Jamaica, which has strong religious and cultural taboos

against homosexuals and bisexuals, it is even more difficult to implement effective AIDS prevention and intervention programs. However, extensive focused interviews have indicated that the strategies and activities outlined in this Project Paper are feasible and socially sound and that they are unlikely to encounter significant and effective opposition by raising these issues. The strategy of directing a sub-campaign on AIDS education and prevention toward the high risk groups will enable the Project to assure their ready access to information of special relevance and importance to them without unnecessarily generating opposition.

Jamaica has a long and enviable history of national, parish and local level organizations and groups working for and with local communities on a variety of social problems. The organizations range from churches to the Jamaican Agricultural Society, the Scouts, YMCA and YWCA, and entrepreneur-based service clubs such as the Optimists Clubs and Kiwanis. All of the private organizations mentioned, in particular those with experience in community participation, are potential vehicles for dissemination of AIDS and STD prevention information. In addition, in view of the importance of music to Jamaican society, and the influence of both reggae stars and disk jockeys, popular recording artists, record companies, and music broadcasters are a potential resource. Notably, a few of the popular reggae groups have recorded songs that carry anti-drug, anti-AIDS, and anti-STDs messages, some of them with support and assistance from ACOSTRAD. There is also the potential to involve private sector advertising agencies in developing and producing mass media messages.

D. Administrative Analysis

In designing the institutional arrangements for the Project, the Project Design Team members considered the following:

- The scarce resources available to the Epidemiology and STD Units through existing budgetary mechanisms to undertake AIDS and STD surveillance and prevention activities that fall within their purview;
- The GOJ budget, budget planning, and Project management requirements that in some cases hamper the ability of the MOH and its individual units to effectively undertake public health tasks, including, for example, delays in arrangements for hiring of staff when posts are available, lack of sufficient posts for critical activities (e.g., Contact Investigators), delays in purchase of commodities, lack of flexibility in expenditures, and insufficient budgetary information available to the individual Units (which frequently are not provided with information regarding their full budget, which would enhance their ability to plan for activities);

- The fact that certain activities can be carried out only by the MOH, such as AIDS and STD surveillance (with the exception of special studies that can be at least partially contracted to other organizations), coordination and implementation of prevention activities, and development and promulgation of national policies; and
- The important roles which the National AIDS Committee can play, and the roles which ACOSTRAD has played and can continue to play, in supplementing the role of the MOH.

In light of these considerations, and the purpose of the Project to reduce transmission of HIV and the incidence and prevalence of STDs in Jamaica, it was determined that the primary grantee would be the Ministry of Health, with ACOSTRAD receiving a sub-grant from the MOH, and with buy-in arrangements with the centrally funded (AID/W) AIDSCOM and AIDSTECH projects.

Given the managerial limitations which the analysis has identified, the Project will provide the necessary strengthening of the implementing institutions to carry out the Project activities in the short-term, and to address AIDS/STD prevention and control activities in the long term.

VII. CONDITIONS AND COVENANTS

A. Conditions Precedent

The Grant Agreement will contain the Standard Conditions Precedent of a legal opinion and a statement of authorized representatives.

Prior to first disbursement of funds for training under the Project, the Grant Agreement will also require the submission of a training plan that will detail overseas and in-country training by year for the first two years, with general training targets outlined for the remainder of the project and outline criteria for selection of participants in both in-country and overseas training.

B. Project Covenants

In addition to the standard Covenant regarding evaluation, the GOJ will covenant to:

- Hire a minimum of five contact investigators each year for three years beginning in the first year of the Project, at a salary level adequate to attract qualified candidates, and to fully fund them in the GOJ budget by the end of the Project; and
- Purchase the basic minimum requirements for STD drugs in a phased manner and assume full responsibility for their purchase by the end of the Project.

VIII. EVALUATION ARRANGEMENTS

The purpose of the evaluation activities will be to determine:

- The extent to which the Project's goal and purpose are being achieved;
- The extent to which the Project is having the desired impact in terms of identified outputs; and
- The extent to which the Project and its strategies and activities continue to be relevant to the objectives and needs of the GOJ with regard to prevention of AIDS and STDs.

Because of the critical nature of the AIDS/STD worldwide epidemic and of the current and potential AIDS and STD situations in Jamaica, it is considered imperative that the Project be closely monitored. In addition, it is expected that a mid-point Project assessment will be carried out in Year 2, with a final evaluation in Year 5 that will also examine the need for follow-on activities. These evaluations will be conducted by external evaluators funded by the Project. They will be selected jointly by USAID and the MOH and will be on-site in Jamaica for at least two weeks for each evaluation. The data collection and review of reports related to these evaluations will be done in collaboration with the USAID, the MOH Project Implementation Unit and the MOH Project Coordination Committee.

One important role of the evaluators will be to work with USAID and the MOH to identify progress toward achievement of those indicators identified in the Logframe and to determine whether those indicators should be revised, supplemented, or in some instances deleted, given potential current changes in epidemiology of both AIDS and STDs and changes in technologies available to prevent or treat these diseases.

PP Text
Endnotes and References

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3. Pan American Health Organization/Kingston. Hospital Restoration Project Interim Report. Kingston: Pan American Health Organization Kingston, Jamaica. April, 1987, Table 1.28.
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5. According to official reports (e.g., Planning Institute of Jamaica. Economic and Social Indicators 1987. Kingston: 1987, p. 15.3) and MOH officials, the rate of under-reporting of infant deaths is very high in Jamaica -- as much as 30% or more in some parishes -- and varies considerably by parish.
6. World Bank. Health, Population and Nutrition Department. Staff Appraisal Report: Jamaica. Washington, D.C.: The World Bank. May, 1987, p. i.
7. National Literacy Survey. JAMAL Foundation, 1981 (cited in Samuels, op cit.
8. For discussion of nutritional factors, see for example: Gonzales, J.P. et al, Malnutrition and HIV Antibody Prevalence in the Central African Republic. Paper presented at the III International AIDS Conference, Washington, D.C., June, 1987, or Scott, JP. Allergy and Nutrition Factors in AIDS and Other Immune System Dysfunctions. San Francisco: Health Kinesiology Center of San Francisco, 1987.
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12. World Bank, op cit, p. i
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14. National Committee on Drug Abuse. Survey of Drug Abuse in Jamaica. Final Report, in process, 1987.
15. Confidential MOH Source.
16. Longworth, G. Update on Alcohol and Alcoholism in Jamaica. The Jamaican Practitioner. Vol. 7, No. 2. September, 1987, p. 21.
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19. Health Information Unit, MOH, reported in: PAHO Hospital Restoration Project Interim Report, op cit, Table 1.28.
20. Samuels, op cit, p. 183
21. Samuels, op cit, p. 105
22. Epidemiology Unit, Ministry of Health, unpublished statistics.
23. Epidemiology Unit. AIDS Summary - December 1982 - April 30, 1988. Kingston: Ministry of Health, May 4, 1988, p. 1
24. Epidemiology Unit, op cit, p. 3
25. Epidemiology Unit, op cit, p. 6
26. United States Program. AIDS Weekly Surveillance Report. Atlanta: Centers for Disease Control, April 11, 1988.
27. Epidemiology Unit. AIDS Summary - December, 1982 - April 30, 1988, p. 4
28. ARC is a disease condition caused by infection with the HIV virus, excluding the specific life-threatening illnesses used to diagnose "full-blown" AIDS. Estimates are that approximately 10%-20% of those with ARC will eventually develop AIDS. Diagnosis is difficult because the infections associated with ARC are much more common than those (e.g., Kaposi's Sarcoma) that are associated with AIDS.

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34. Brathwaite, AR. STD Control Programme Annual Report 1987. Kingston: Ministry of Health February, 1988, p. 13.1
35. Data provided by Dr. Alfred Brathwaite, SMOH, STD Unit. The data for St. Ann Parish include only February and March of 1988.
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38. A 1983 study of herpes genitalis showed 621 cases in Kingston, according to the SMOH for the STD Unit.
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40. Murphy, E., Figueroa, P., Gibb, W.N., et al. Retroviral Epidemiology in Jamaica, West Indies: Introduction of HIV into an HTLV-1 endemic Island. Poster presentation at the III International Conference on AIDS, 1987.
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42. Belsey, E.M. Sexually Transmitted Disease Surveillance in Jamaica. Washington, DC: Pan American Health Organization, July, 1986, p. 1
43. Jillson-Boostrom, I.A. The Socio-economic Impact of AIDS in Jamaica. Clarksville, Maryland: Policy Research Incorporated. Project funded by USAID/Jamaica. 1987.
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45. Interview with Dr. A. Brathwaite, op cit.
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50. Gruson, L. Condoms: Experts Fear False Sense of Security. New York Times, Tuesday, August 18, 1987, p. C1 ff.
51. World Bank, op. cit., p.7.
52. For discussion of the impact of STDs on other health problems, see Parra, W.C. and Cates, W. Progress Toward the 1990 Objectives for Sexually Transmitted Diseases: Good News and Bad. Public Health Reports., Vol. 100, No. 3, May-June, 1985, pp. 261-269.
53. Epidemiology Unit. National Plan for AIDS Prevention and Control. Kingston: Ministry of Health, 1987.
54. Sexually Transmitted Diseases Unit. STD Control Programme Annual Report 1987. Kingston: Ministry of Health, 1988

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SECTION: AID-5 INFO: AMB DCM ECON POL

Annex A.
PID Approval Cable

WZCZCTROP17
OO RUEHAC
DE RUEHC #0251/01 130025Z
ANN BUJUH 22H
O 130249Z MAY 89
FM STATE WASHDC
TO AMEMBASSY KINGSTON IMMEDIATE 6755
BT
UNCLAS SECTION 31 OF 03 STATE 150251

10 MAY 89
TIME: 1300
INFO: 13017
FROM: AID
TO: AID
ATTN:

R.G. 12355: N/A
TAGS:
SUBJECT: CT: USAID/JAMAICA HEALTH SECTOR INITIATIVES PID
(532-0152) REVIEW

1. THE DAEC FOR USAID/JAMAICA HEALTH SECTOR INITIATIVES PID WAS HELD ON TUESDAY, APRIL 26, 1989. THE MISSION IS COMMENDED FOR DESIGNING A PROJECT WITH CLEAR PRIORITIES AND WHICH TARGETS SPECIFIC INTERVENTION AREAS IDENTIFIED IN THE MISSION'S RECENT HEALTH SECTOR ASSESSMENT WHERE A.I.D. COULD BE MOST EFFECTIVE. THE PID IS APPROVED AND THE BUREAU CONCURS WITH MISSION DELEGATION OF AUTHORITY TO APPROVE AND AUTHORIZE THE PROJECT PAPER, SUBJECT TO THE GUIDANCE HEREIN AND THE EXCEPTION IN PARAGRAPH 2(D).

2. CLARIFICATIONS:

THE FOLLOWING POINTS WERE CLARIFIED AT THE ISSUES MEETING HELD ON WEDNESDAY, APRIL 28:

(A) HEALTH SECTOR ASSESSMENT - QUESTIONS WERE RAISED CONCERNING JAMAICA'S HEALTH SECTOR ASSESSMENT, SUBMITTED IN OCTOBER, 1987, AND WHETHER A REVIEW OF THE DOCUMENT

HAD BEEN CONDUCTED BY THE BUREAU. LAC/DR/HH ALONG WITH PPC AND S AND T PARTICIPATED IN THE REVIEW, HELD IN OCTOBER, 1987, AND CONCURRED WITH THE ASSESSMENT, WHICH JUSTIFIED THE MISSION'S POSITION TO REMAIN IN THE HEALTH SECTOR AND SELECTION OF THE HEALTH SECTOR INITIATIVES PROJECT WHICH ADDRESSES CONSTRAINTS TO QUALITY HEALTH CARE AND COMPLEMENTS AN ON-GOING LPRD PROJECT.

(B) HEALTH SERVICES INITIATIVES SECRETARIAT (HSIS) - SEVERAL QUESTIONS WERE RAISED ON THE OPERATION OF HSIS, E.G., SUSTAINABILITY AND EMPLOYMENT OF PERSONNEL. HSIS PERSONNEL WILL BE CONTRACTORS HIRED BY THE MINISTRY OF HEALTH. HOWEVER, HSIS IS A PROJECT SPECIFIC UNIT AND THERE ARE NO PLANS FOR HSIS TO REMAIN AFTER PROJECT COMPLETION.

(C) PROJECT MANAGEMENT - CONCERN WAS EXPRESSED ABOUT THE MANAGEMENT INTENSITY OF THIS PROJECT AND WHETHER THE MISSION COULD HANDLE IMPLEMENTING TWO MAJOR COMPONENTS.

2(A) - N/A

2(B) - N/A

Response to 2(C) - Project Management:

The Health Sector Initiatives Project as proposed in the PID has been broken into two projects; the Mission decided that on balance, AID/W's point was persuasive. Implementation of the AIDS/STD component which comprises this Project will be facilitated since the Project will be on stream in advance of the health financing component, proposed to begin in FY89. In addition, the Project has built in management capability, including a Project Manager in the MOH and two local consultants in the Ministry of Health who will facilitate Project implementation.

PID APPROVAL CABLE AND DAEC RESPONSE ANNEX A

DATE RECEIVED:	5/18
ACTION OFFICE:	ODDS
INFO TO:	
DIR ✓	ARDO
D/DIR ✓	OHNP ✓
OPEP ✓	GEHR
OPDS	OPED
OSBE	OCM
EXO	RHDD
CONT	R.R. ✓
DATE:	5/19
BY:	5/25 MKNed

HEALTH CARE FINANCING AND AIDS/STD PREVENTION. THE MISSION PLANS TO USE A PSC AND PRIMS CONTRACTOR FOR THE PROJECT AND WILL EXPLORE THIS ISSUE FURTHER DURING PROJECT DEVELOPMENT.

Response to 2(D) - Counterpart Funds:

The IDB Hospital Restoration Project is not yet approved, and therefore is not requiring the allocation of major counterpart funds. USAID does not anticipate any problem in the GOJ allocating US\$850,000 as their contribution.

3(A) - N/A

3(B) - N/A

Response to 3(C) - Too Many Components:

In response to the concern raised by AID/W, the Project is concentrating in three areas only. These areas build upon USAID's relative advantage given our past experience and expertise, i.e. operations research; prevention, and education.

(D) OTHER DONOR ACTIVITIES - OTHER DONORS ARE CURRENTLY FINANCING HEALTH PROJECTS IN JAMAICA WHICH COMPEL A REASSESS THE GOJ'S ABILITY TO PROVIDE COUNTERPART FUNDS TO A.I.D. FINANCED PROJECTS. IBRD IS CURRENTLY FUNDING PRIMARY HEALTH CARE AND POPULATION ACTIVITIES, AND IDB HAS PROPOSED FUNDING HOSPITAL RATIONALIZATION AND RENOVATION. IN LIGHT OF THESE ACTIVITIES THE PROJECT PAPER SHOULD ANALYZE THE EXPECTED GOJ COUNTERPART CONTRIBUTIONS TO ENSURE THAT OTHER DONOR ACTIVITIES DO NOT IMPINGE ON THE GOJ'S CAPACITY TO SUCCESSFULLY IMPLEMENT THE PROPOSED PROJECT.

3. ISSUES RESOLVED:

THE FOLLOWING ISSUES WERE RESOLVED AT THE PID ISSUES MEETING:

(A) PRIVATE SECTOR DESIGN DEVELOPMENT - THE PID'S PROPOSED ACTIVITIES WITH THE PRIVATE SECTOR RAISED CONCERNS ABOUT THE ACTUAL EXTENT OF PRIVATE SECTOR INVOLVEMENT IN PROJECT DESIGN. MANY OF THE PROJECT ACTIVITIES WILL BENEFIT THE PRIVATE SECTOR AND A NUMBER

OF STUDIES WILL LOOK AT HOW THE PRIVATE SECTOR THINKS. A.I.D. HAS OFTEN NOTED THE BENEFITS OF BENEFICIARY INVOLVEMENT IN PROJECT DESIGN. THE MISSION WILL ENSURE THAT THE PRIVATE SECTOR WILL BE BROUGHT INTO THE PROJECT DEVELOPMENT PROCESS EARLY AND WILL EXPLORE THE POSSIBILITY OF CO-FINANCING OF SOME PROJECT ACTIVITIES. E.G., FEASIBILITY STUDIES WITH THE PRIVATE SECTOR.

(B) TERMS OF AID THE PROPOSED PROJECT WILL ESTABLISH THE PRIVATE SECTOR EXPANSION INCENTIVE FUND (PSEIF). TO INCREASE PRIVATE SECTOR CAPABILITY IN HEALTH CARE DELIVERY. ACCORDING TO GUIDELINES ON TERMS OF A.I.D. ASSISTANCE, GRANTS TO THE PRIVATE SECTOR MUST COMPLY WITH SPECIFIC GUIDANCE, ENSURING THAT THE VALUE OF ANY BENEFITS TO BE RECEIVED BY THE GRANTEE WILL BE IDENTIFIED AND ANALYZED. THE MISSION WILL ENSURE THAT THE PROJECT IS IN ACCORDANCE WITH A.I.D. POLICY ON GRANTS TO THE PRIVATE SECTOR.

(C) AIDS/STD COMPONENT - CONCERN WAS EXPRESSED ABOUT THE WIDE ARRAY OF ACTIVITIES UNDER THE AIDS/STD COMPONENT AND WHETHER THE PROJECT COULD MAKE A

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ANNEX A
PID APPROVAL CABLE AND DAEC RESPONSE
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MEANINGFUL CONTRIBUTION IN SO MANY AREAS.
USAID/JAMAICA WILL CAREFULLY REVIEW THE COSTS OF THE
PLANNED ACTIVITIES UNDER THE AIDS/STD COMPONENT OF THE
PROJECT TO ENSURE SUFFICIENT FUNDING IS ALLOCATED TO
ACCOMPLISH THESE ACTIVITIES AND CONSIDER REDUCING THE
NUMBER OF ACTIVITIES ASSISTED AND SEEK OTHER FONDS
INVOLVEMENT IN FINANCING OUT SOME OF THE ACTIVITIES.

(B) HOSPITAL MANAGEMENT - CONCERN WAS RAISED OVER THE
PROPOSED PROJECT'S HEAVY EMPHASIS ON TECHNICAL
ASSISTANCE AND LESS EMPHASIS ON TRAINING. IN LIGHT OF
PREVIOUS DISCUSSIONS IN PROVIDING TECHNICAL ASSISTANCE
TO THE MINISTRY OF HEALTH UNDER THE CURRENT PROJECT, THE
MISSION WAS REQUESTED TO HIGHLIGHT TRAINING NEEDS OF
THE PROJECT, ESPECIALLY IN THOSE AREAS WHICH WILL
POSITIVELY IMPROVE EFFICIENT OPERATION OF HEALTH CARE
SYSTEM, E.G., HEALTH ADMINISTRATORS.

4. THE FOLLOWING PROJECT ISSUES WERE DISCUSSED AT THE
DAEC REVIEW:

(A) PROJECT DESIGN - THE MISSION SHOULD CAREFULLY REVIEW
PROJECT STRUCTURE AND JUSTIFY REASONS FOR COMBINING WHAT
APPEARS TO BE TWO PROJECTS UNDER ONE: AS OUTLINED IN
THE PID, DIVIDING BETWEEN THE TWO COMPONENTS OF THE
PROJECT IS UNDESIRABLE. THE AIDS/STD COMPONENT IS A

STRAIGHT FORWARD PROJECT WITH DIFFERENT FUNCTIONAL
EMPHASIS FROM THE HEALTH CARE FINANCING COMPONENT, AND
THE TWO COMPONENTS SHOULD USE DIFFERENT IMPLEMENTING
UNITS. COMBINING THE ACTIVITIES INTO ONE PROJECT COULD
MAKE IMPLEMENTATION MORE DIFFICULT AND STAFF INTENSIVE
BECAUSE OF THE ONGOING NEED TO ADDRESS THE COMPONENTS
IN DIFFERENT WAYS. SET OUT ACCOMPLISHMENTS AND JUDGE
PROGRESS OF EACH COMPONENT, AND IN THE FUTURE DEAL WITH
CONTINUED STRUGGLES IN DIFFERENT WAYS. IF, DURING TECHNICAL
ANALYSIS AND PROJECT DEVELOPMENT, THE MISSION BELIEVES
THAT THERE ARE VALID REASONS FOR COMBINING THE TWO
ACTIVITIES UNDER ONE PROJECT, THE PROJECT PAPER SHOULD
CLEARLY DEMONSTRATE THE STRATEGIC RELATIONSHIP BETWEEN
THE TWO COMPONENTS AND THE IMPLEMENTATION BENEFITS OF
LINKAGE. INCLUDE POLICY DIALOGUE.

IF INSTEAD, MISSION WISHES TO PREPARE SEPARATE PROJECTS,
THE PID THAT IS SUBMITTED CAN SERVE AS THE PID FOR BOTH
PROJECTS AND THE DAEC PROVIDES BUREAU CONCURRENCE WITH
MISSION DESIGN. THE DAEC APPROVES THE PROJECT PAPERS AND
AUTHORIZES THE PROJECTS. USAID MUST, HOWEVER, NOTIFY THE
BUREAU BY CABLE OF ALL PLANS TO APPROVE SEPARATE PROJECTS.

(B) FUNDING DESIGN - BECAUSE OF UNCERTAINTIES ABOUT
RESOURCE AVAILABILITY, THE PROJECT SHOULD BE STRUCTURED
TO TAKE INTO ACCOUNT THE POSSIBLE NEED TO RAISE
FUNDING. TO ENSURE THAT THE BASIC OBJECTIVES OF THE
PROJECT ARE MET AT REDUCED FUNDING LEVELS, THE PID
SHOULD: (1) CLEARLY IDENTIFY KEY SUBCOMPONENTS IN THE
PROJECT WHICH COULD BE PHASED IN AND ARE ESSENTIAL TO

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3(D) - N/A

Response to 4(A) - Project structure:

A decision was made by the Mission to
separate the AIDS/STD component out of the
overall Health Sector Initiatives Project.
This information was transmitted to AID/W
by Kingston 005807.

4(B) - N/A

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ACHIEVE PROJECT OBJECTIVES AT CRITICAL FUNDING JUNCTURES, AND (2) MINIMIZE LONG TERM COMMITMENTS, E.G., LONG TERM ADVISORS/CONSULTANTS.

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4(C) - N/A

(C) BENEFICIARIES - THE PP SHOULD INCLUDE A DETAILED ANALYSIS OF WHO THE BENEFICIARIES ARE AND HOW THEY WILL BENEFIT FROM THE PROJECT. ADDITIONALLY, THE POLICY ENVIRONMENT SHOULD BE ANALYZED TO ENSURE THAT THE PROJECT TAKES INTO ACCOUNT ANY INTERVENTION IN THIS AREA REQUIRED TO ENSURE THE PROJECT ACHIEVES ITS OBJECTIVES. THE ANALYSIS SHOULD SPECIFICALLY EXAMINE HOW THE POPULATION SERVED BY PRIVATE FACILITIES COULD BE BROADENED TO INCLUDE LOWER INCOME GROUPS. THE ANALYSIS SHOULD ALSO INCLUDE THE RESULTS OF FURTHER EXAMINATION OF THE WILLINGNESS TO PAY FOR SERVICES ISSUED.

4(D) - N/A

(D) PSEIF: NEED FOR FINANCING - THIS COMPONENT OF THE PROJECT OBVIOUSLY WILL REQUIRE EXTENSIVE ANALYTICAL WORK

PRIOR TO ITS INITIATION, INCLUDING CONFIRMATION THAT CREDIT IS A SIGNIFICANT CONSTRAINT FOR WHICH A UNIQUE AND DISCRETE NEW CREDIT SYSTEM IS REQUIRED. IN ADDITION, SOME OF THE ANALYSIS REQUIRED TO DESIGN THE CREDIT FUND APPEARS TO BE INCLUDED AS AN ELEMENT OF THE PROJECT ITSELF. FOR EXAMPLE, THE SIZE OF THE FUND TO BE AUTHORIZED IS ITSELF A MAJOR ISSUE WHEN VIEWED AGAINST THE TIGHT MORTGAGE SITUATION DISCUSSED IN PARA 4(B) ABOVE.

GIVEN ISSUES OF POTENTIAL POLICY CONCERN (INTEREST RATES, INSTITUTIONALIZATION OF A DISCRETE FUND, CRITERIA FOR QUALIFICATION AND PARTICIPATION OF RECIPIENTS, VALIDITY OF THE ASSUMPTION THAT CREDIT IS A KEY CONSTRAINT IN THE SECTOR), THE MISSION IS REQUESTED TO SUBMIT FOR AID/W REVIEW A DESCRIPTION OF THE FINAL DESIGN OF THE CREDIT COMPONENT PRIOR TO THE AUTHORIZATION OF THE FUND. THE DESCRIPTION SHOULD INCLUDE INFORMATION ON FUND STRUCTURE (ELIGIBILITY CRITERIA, INTEREST RATES, INSTITUTIONAL ARRANGEMENTS, MISSION INVOLVEMENT IN IMPLEMENTATION/CURIOAN APPROVAL)

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AS WELL AS A SUMMARY OF THE ANALYSIS SUPPORTING THE NEED FOR A FREE-STANDING CREDIT LINE.

AT ITS OPTION, THE MISSION MAY WISH TO SHIFT DETAILED DESIGN OF THE CREDIT FUND INTO THE PROJECT AND PROCEED TO DEVELOP AND AUTHORIZE THE PP ALONG THAT LINE. THIS CREDIT COMPONENT COULD THEN BE ADDED AS AN AMENDMENT AT A LATER STAGE. IF, HOWEVER, THE MISSION WISHES TO PROCEED WITH THE FULL ANALYSIS DURING INTENSIVE REVIEW, AID/W CONCURRENCE WILL BE REQUIRED PRIOR TO AUTHORIZATION OF THE OVERALL PROJECT. OUR CONCERN IS THAT THE AIDS/STD COMPONENT MAY BE DELAYED SIGNIFICANTLY IF THE DEVELOPMENT OF THE CREDIT FUND PROVES LENGTHY.

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ANNEX B. Logical Framework

: NARRATIVE SUMMARY	: OBJECTIVELY VERIFIABLE INDICATORS	: MEANS OF VERIFICATION	: ASSUMPTIONS
: PROJECT GOAL : Improve health status of the : Jamaican people.	: National STD and AIDS rates stable : or reduced	: Health and Vital : Statistics	: (Purpose-to-Goal : Assumptions) : Policies and programs of : the Ministries of Health, : Education, and Labor will : be supportive of project : objectives
: PROJECT PURPOSE : To reduce STD and HIV transmission : in Jamaica and the incidence and : prevalence of STDs in Jamaica.	: EOPS * : - 10% reduction in estimated : number of HIV seropositive persons : (below current est. of 3,000) : - Annual reported cases of : congenital syphilis 30 or below : (from 36 in 1987) : - Blood donor syphilis : seropositivity rate 4% or below : (30% below 1987 rate of 6%) : - Culture-proven gonorrhea rate in : under-20 population reduced by 20% : from 1988 baseline	: MOH Information System : Reports from private : laboratories : Reports from private : organizations engaged : in prevention : activities	: Other donor support : available as planned : Restrictions on AID : funds to Jamaica are : lifted : (Output-to-Purpose : Assumptions) : AIDS and STDs will : continue to be an MOH : priority
: OUTPUTS : Increased on-going surveillance : capacity on part of the MOH : 8 additional operational MOH : STD clinics : 15 additional contact investi- : gators working in AIDS & STD : surveillance : MOH laboratories able to absorb : increased demand for testing : for STDs : KAP and other surveys conducted : Operations Research studies : conducted among high-risk groups : periodically	: OUTPUT INDICATORS : 2,000 additional persons screened : for STDs in 1989, 5,000 in 1990 : and 10,000 thereafter : 3 STD surveys completed : 4 AIDS/STD KAP surveys completed : 10 completed studies	: STD clinic records : On-site evaluation visits: : STD clinic records : MOH personnel records : MOH records : MOH records	

OUTPUTS (Continued)	OUTPUT INDICATORS		
MOH and private sector have on-going mass media campaign with linkages to targetted prevention strategies	80% of general public aware of risks of AIDS and STDs and aware of preventive measures	Results of periodic KAP studies	
National AIDS Hotline operational	5,000 calls received per year	Hotline records	
MOH and private sector have prevention activities directed toward high-risk groups	90% of high risk group members aware of risks of AIDS and STDs and aware of preventive measures	Results of periodic KAP studies of high-risk populations	
Education and prevention activities on-going in public schools	75% of children grades 7-12 have received AIDS/STDs information	Project records/MOE records	
MOH and private sector implement prevention strategies directed toward adolescents, women of child-bearing age, and other target populations	75% of women attending MCH clinics have received AIDS/STD education	MOH clinic records	
	5,000 adolescents have been reached outside the school system	Project records & targeted KAP studies	
Improved MOH capacity to treat STDs	0 shortfall in avail. of STD drugs	STD clinic records and on-site visits	
Improved capacity of MOH and private sector personnel to implement AIDS/STDs policies and programs	400 MOH and 100 private sector medical personnel trained in AIDS/STDs prevention and knowledgeable about intervention measures	Project records and surveys of physicians	
National AIDS Committee meeting regularly to provide advice re: MOH policies and programs	Quarterly meetings held	Review of meeting minutes & MOH policies	
Increased MOH capacity to undertake health services research and policy and program evaluation	25 MOH personnel trained in HSR and evaluation 10 MOH personnel trained in use of microcomputers/software	Project records & survey of staff Project records & survey of staff	(Input-to-Output Assumptions) Inputs available on a timely basis
INPUTS			
Long Term Jamaican TA Short Term US TA Short Term Jamaican TA Commodities Training Local Costs	See Table I in Section II.A.	Project documents	

* It should be noted that the EOPS takes into account the fact that improvements in MOH surveillance and individual physician reporting are likely to result in an increase in the number of reported cases of AIDS and STDs. This, as well as the dearth of reliable baseline data, renders selection of valid and appropriate epidemiologic indicators of Project achievement difficult. An important achievement of the Project will be the development of more adequate baseline data.

ANNEX C. Statutory Checklist

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3M(2) - PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A includes criteria applicable to all projects. Part B applies to projects funded from specific sources only: B(1) applies to all projects funded with Development Assistance; B(2) applies to projects funded with Development Assistance loans; and B(3) applies to projects funded from ESF.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?
 Yes. Country Checklist completed with FY88 PAAD 12/87
 Yes.

A. GENERAL CRITERIA FOR PROJECT

1. FY 1988 Continuing Resolution Sec. 523; FAA Sec. 634A. If money is sought to obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified? Yes
2. FAA Sec. 611(a)(1). Prior to an obligation in excess of \$500,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance, and (b) a reasonably firm estimate of the cost to the U.S. of the assistance? Yes
3. FAA Sec. 611(a)(2). If legislative action is required within recipient country, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance? N/A
4. FAA Sec. 611(b); FY 1988 Continuing Resolution Sec. 501. If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.) N/A
5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively? N/A

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6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.

No; N/A

7. FAA Sec. 601(a). Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions. The improved MOH & Private Sector capability to implement & plan AIDS/STD related activities will indirectly contribute to the

8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise). All such effects would be indirect except insofar as U.S. private firms will provide TA or

9. FAA Secs. 612(b), 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars. The GOJ is contributing over 25% of the total cost of the proj. in local currency or in kind.

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? The U.S. does not own any Ja. currency.

No

11. FY 1988 Continuing Resolution Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?

N/A

12. FY 1988 Continuing Resolution Sec. 553. Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel?

N/A

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13. FAA Sec. 119(g)(4)-(6). Will the assistance (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas? (a) No; (b) No; (c) No; (d) No

14. FAA 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)?

N/A

15. FY 1988 Continuing Resolution. If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government?

N/A

16. FY Continuing Resolution Sec. 541. If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.?

N/A

17. FY 1988 Continuing Resolution Sec. 514. If funds are being obligated under an appropriation account to which they were not appropriated, has prior approval of the Appropriations Committees of Congress been obtained?

N/A

18. FY Continuing Resolution Sec. 515. If deob/reob authority is sought to be exercised in the provision of assistance, are the funds being obligated for the same general purpose, and for countries within the same general region as originally obligated, and have the Appropriations Committees of both Houses of Congress been properly notified?

N/A

19. State Authorization Sec. 139 (as interpreted by conference report). Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision).

N/A

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B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FY 1988 Continuing Resolution Sec. 552 (as interpreted by conference report). If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities (a) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (b) in support of research that is intended primarily to benefit U.S. producers? N/A

b. FAA Secs. 102(b), 111, 113, 281(a). Describe extent to which activity will (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries. By improving health status, the proj. will effectively increase the capability of the poor/women to participate in the

c. FAA Secs. 103, 103A, 104, 105, 106, 120-21. Does the project national economy fit the criteria for the source of funds (functional account) being used?
 Yes

d. FAA Sec. 107. Is emphasis placed on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)? Technology selected is based on extensive project analysis.

e. FAA Secs. 110, 124(d). Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?

Jamaica is contributing over 25% of total project costs.

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f. FAA Sec. 128(b). If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?
Yes

g. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government. Project was jointly developed by AID & MOH & will provide inputs to increase capacity of MOH. A majority of the planned I.A. will be provided by Jamaicans.

h. FY 1988 Continuing Resolution Sec. 538. Are any of the funds to be used for the performance of abortions as a method of family planning or, to motivate or coerce any person to practice abortions?
No

Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations?
No

Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?
No

i. FY 1988 Continuing Resolution. Is the assistance being made available to any organization or program which has been determined to support or participate in the management of a program of coercive abortion or involuntary sterilization?
No

If assistance is from the population functional account, are any of the funds to be made available to voluntary family planning projects which do not offer, either directly or through referral to or information about access to, a broad range of family planning methods and services?
No

j. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?
Yes

k. FY 1988 Continuing Resolution. What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 20 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?
The majority of the AID Direct contracts will be through buy-ins to existing competitively awarded contracts.

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1. FAA Sec. 118(c). Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16? Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (a) stress the importance of conserving and sustainably managing forest resources; (b) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (c) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (d) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (e) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded; (f) conserve forested watersheds and rehabilitate those which have been deforested; (g) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (h) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (i) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (j) seek to increase the awareness of U.S. government agencies and other donors of the immediate and long-term value of tropical forests; and (k) utilize the resources and abilities of all relevant U.S. government agencies?

Yes

N/A

m. FAA Sec. 118(c)(13). If the assistance will support a program or project significantly affecting tropical forests (including projects involving the planting of exotic plant species), will the program or project (a) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land, and (b) take full account of the environmental impacts of the proposed activities on biological diversity?

N/A

n. FAA Sec. 118(c)(14). Will assistance be used for (a) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; or (b) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas?

No

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o. FAA Sec. 118(c)(15). Will assistance be used for (a) activities which would result in the conversion of forest lands to the rearing of livestock; (b) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undegraded forest lands; (c) the colonization of forest lands; or (d) the construction of dams or other water control structures which flood relatively undegraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

No

p. FY 1988 Continuing Resolution If assistance will come from the Sub-Saharan Africa DA account, is it (a) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; (b) being provided in accordance with the policies contained in section 102 of the FAA; (c) being provided, when consistent with the objectives of such assistance, through African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in Sub-Saharan Africa; (d) being used to help overcome shorter-term constraints to long-term development, to promote reform of sectoral economic policies, to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities, to bring about appropriate sectoral restructuring of the Sub-Saharan African economies, to support reform in public administration and finances and to establish a favorable environment for individual enterprise and self-sustaining development, and to take into account, in assisted policy reforms, the need to protect vulnerable groups; (e) being used to increase agricultural production in ways that protect and restore the natural resource base, especially food production, to maintain and improve basic transportation and communication networks, to maintain and restore the natural resource base in ways that increase agricultural production, to improve health conditions with special emphasis on meeting the health needs of mothers and children, including the establishment of self-sustaining primary health care systems that give priority to preventive care, to provide increased access to voluntary family planning services, to improve basic literacy and mathematics especially to those outside the formal educational system and to improve primary education, and to develop income-generating opportunities for the unemployed and underemployed in urban and rural areas?

N/A

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2. Development Assistance Project Criteria (Loans Only) N/A

a. FAA Sec. 122(b). Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest.

b. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?

c. FY 1988 Continuing Resolution. If for a loan to a private sector institution from funds made available to carry out the provisions of FAA Sections 103 through 106, will loan be provided, to the maximum extent practicable, at or near the prevailing interest rate paid on Treasury obligations of similar maturity at the time of obligating such funds?

d. FAA Sec. 122(b). Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities?

3. Economic Support Fund Project Criteria N/A

a. FAA Sec. 531(a). Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA?

b. FAA Sec. 531(e). Will this assistance be used for military or paramilitary purposes?

c. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?



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ANY REPLY OR SUBSEQUENT REFERENCE TO THIS COMMUNICATION SHOULD BE ADDRESSED TO DIRECTOR GENERAL, PLANNING INSTITUTE OF JAMAICA, 39-41 BARBADOS AVENUE.

PIOJ

PLANNING INSTITUTE OF JAMAICA

TELEX 3529, PLANJAM JA
P.O. BOX 634,
KINGSTON,
JAMAICA.

DATE RECEIVED:	8/23
ACTION OFFICE:	OHNP
INFO TO:	
DIR ✓	ARDO
D/DIR ✓	OHNP
OPEP ✓	GEHR
OPDS ✓	OPED
OEEE	OCM
EXO ✓	RHUDO
CONT ✓	R.F. ✓
BY:	9/1
ACTION:	

August 22, 1988

Mr. William B. Joslin
Director, USAID
2 Oxford Road
Kingston 5

Dear Mr. Joslin,

Re: AIDS/STD Prevention and Control

Attached, please find a copy of the captioned project to be funded jointly by the Government of Jamaica and the United States Agency for International Development.

The development of this project is predicated on the fact that AIDS is regarded as perhaps the most serious health problem facing the country. In view of the fact that AIDS is, in addition to other ways, sexually transmitted, the project will also focus on Sexually Transmitted Diseases (STDs).

The total estimated cost of the project is put at US\$3.35 million, of which the USAID is requested to finance US\$2.50 million or approximately 75 per cent of total project costs.

This letter constitutes a formal request for USAID financing of US\$2.50 million to support implementation of the AIDS/STD Prevention and Control project estimated to cost US\$3.35 million.

We look forward to a positive response to our proposal.

Sincerely,


Winston Anderson
for Director General

Attachment:

Copied to: Director General
Mrs. Merle Henry
Mr. Rupert Ramcharan, P.S.,
Ministry of Health

ANNEX E. TECHNICAL ANALYSIS

The objective of this technical analysis, pursuant to Handbook 3, is to "ascertain whether the design of...[the] project ... is consistent with the body of knowledge about possible solutions...within the cognizant professional community" with regard to AIDS and STDs transmission, and whether the proposed component activities are "technically the most suitable and cost-effective.

Three major sets of implementation actions are identified, namely: 1) Surveillance activities, 2) Prevention activities, and 3) Strengthening of the MOH and private sector capabilities with respect to the above.

The surveillance activities are suitable inasmuch as they are designed to meet the direct needs of the MOH to more efficiently and effectively identify those who are HIV+ and who have STDs, in order to both treat those individuals and reduce transmission of the diseases.

Prevention activities seek to utilize existing public and private sector resources to the maximum extent possible in order to carry out a variety of strategies designed to address both the general public and the multiple target populations. The latter includes both groups most at-risk for AIDS and STDs, and others such as adolescents for whom primary prevention strategies are designed to minimize contagion. Further, the prevention activities will make maximum use of those that have proved successful in the U.S. and elsewhere and which can be adapted for the Jamaican context. This includes, for example, educational, counseling and training of health personnel activities. Many of the materials used will be available at minimal or no cost by virtue of the fact that they are in the public domain having been developed with public funds in the U.S.). Approaches that have proved successful in the Latin American and Caribbean (LAC) area specifically will be sought for MOH consideration.

Suitability of Major Actions

In considering the general components to include in the AIDS/STD project, consideration has been given to a number of alternative approaches to surveillance and treatment that have viewed as inappropriate. These are discussed below.

Mandatory Testing. Mandatory AIDS testing of high-risk populations is not recommended by WHO, and has been used in few countries. A notable exception is the U.S., which tests military recruits, State Department employees being assigned overseas, and foreigners applying for immigrant visas. One

state in the U.S. (Illinois) has a mandatory program for testing those applying for marriage licenses. Each of these mandatory testing programs is highly controversial, has been criticized by the public health community (including officials in the Public Health Service and the Centers for Disease Control). Mandatory testing programs are very expensive, difficult to manage, and of questionable utility in preventing transmission. In addition, they raise serious ethical issues that have yet to be resolved. Mandatory testing is not recommended as part of this Project. The MOH, with the National AIDS Commission, needs to consider the advantages and disadvantages of implementing any WHO recommendations, and the experience of other countries, in particular the experience of developing countries, in designing and implementing such programs, in their utility, and in confronting the ethical issues raised by such programs.

Support for use of AZT in Treatment of AIDS. The GOJ has determined that it will not use AZT in the treatment of AIDS in view of its excessive cost (approximately US\$8,000 per year per patient), and limited success. It has determined that at such time as the cost of the drug (or any other drug that becomes available) is affordable by the MOH, and has proven effectiveness, that purchase of such drugs will be considered. This decision has been concurred by the USAID AIDS consultant and by the PHN Office of the Mission.

No Prevention or Treatment Components. In view of the high rates of STDs in Jamaica, and the increasing rates of AIDS, the alternative of no support for prevention or treatment components is considered inappropriate, for the following reasons:

- 1) the cost of the prevention programs and of the minimal support for treatment efforts included in this project is far outweighed by the potential economic benefits (see Economic Analysis);
- 2) ethical considerations inveigh against preclusion of prevention or treatment components in view of the personal health and social impact of AIDS and STDs as Project Components. In addition, in the conduct of any research or demonstration projects there will be no withholding of treatment or opportunities for some form of prevention. Guidelines in use in the U.S. for conduct of experiments involving human subjects will be used in conjunction with such guidelines which may be in force in Jamaica.

Generally, surveillance and prevention activities with regard to STDs are known to and accepted by the public health community; these include, for example:

- early detection and treatment;
- contact investigation of individuals known to be infected, and notification of the partners of those individuals;
- mandatory reporting of certain types of STDs by public and private physicians (i.e., notifiable diseases);
- use of mass media campaigns directed toward the general public and targeted education programs (e.g., to such diverse populations as military recruits and school children).

These are the types of activities that are proposed for the AIDS/STD Project.

In the U.S., there have been substantial reductions in incidence of some common STDs (such as gonorrhoea and syphilis), due in large part to the success of the types of activities listed above. However, there has been a resurgence of even these STDs among certain sub-populations, and herpes genitalis has been considered of epidemic proportions by the Public Health Service. This is in the context of a public health system that has ample resources to allocate on a national, state, and local basis to surveillance and prevention.

In the Jamaican context, these types of activities are perceived as appropriate, but the severe lack of resources has significantly impeded effective implementation of any of these approaches to STD surveillance and prevention. A 1986 PAHO report noted important deficiencies in resources available to the STD unit, including inadequate number of staff, particularly contact investigators (only 10 of 39 requested posts have been approved for the MOH, and only 7 of these 10 are currently filled), and inadequate training of staff, and lack of critical medical equipment, including microscopes and autoclaves, at the MOH STD clinics. Nearly two years after this report was submitted, the situation has improved little, due to a shortage of funds. Moreover, the urgent need for training of clinic staff to improve the problem of patient flow noted by another PAHO consultant in 1986 ¹/ has not been met, and there is the added problem of a severe shortage of medications, particularly those to be used in treatment of resistant strains of gonorrhoea. The types of problems identified by the PAHO consultant that still pertain in mid-1988, and which

severely hamper the ability of the MOH to effectively implement the activities described above include:

- specialized services for the treatment of STDs are available in only six of the 14 parishes;
- although the Comprehensive STD Clinic (the principal governmental STD clinic) and the six other clinics had laboratory facilities, the supplies and equipment available rendered them inadequate to the task of detection and screening; for example:
- a microscope is available for use in only three of the six STD clinics;
- only two of the clinics have the facilities to culture gonorrhea;
- only one of the clinics has a functioning darkfield microscope; and
- there is still a severe shortage of contact investigators, with only 7 presently working for the MOH.

The AIDS/STD Project will contribute significantly to the ability of the MOH and the private sector to effectively implement the surveillance and prevention strategies by providing staff and equipment necessary for detection and screening and contact investigation, and resources for both mass media and targeted education efforts.

With regard to preventing the transmission of HIV (the AIDS virus), the onset of the disease, and technologies available to prevent its transmission are relatively new (the first case having been diagnosed in the U.S. in 1981). The approaches to prevention of transmission that are generally accepted by WHO, the U.S. Centers for Disease Control, and the Jamaican Ministry of Health, are:

- screening of the public blood supply (which has been done in Jamaica since 1985);
- voluntary periodic testing of members of "high-risk" groups;
- public and targeted education, with clear messages regarding transmission of the disease and the need for individual action regarding such transmission; and
- ensuring an adequate and readily available supply of condoms.

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The activities proposed in the Surveillance and Prevention components of the Project Paper pertain directly to these approaches, and in addition consider the Jamaican context in particular. For example, there is a focus on the groups most at-risk in Jamaica (prostitutes, farm workers, women of child-bearing age, and homosexual and bisexual men). There is also a recognition of the fact that, in addition to the important and necessary function of the MOH and ACOSTRAD, the most effective and efficient means of accessing some of these populations may not be through the MOH, but rather through formal or informal grassroots organizations, or through individuals connected with these organizations. This will be accomplished through the mechanisms of small contracts or grants.

There have thus far been no cost-effectiveness studies of alternative AIDS and STD surveillance and prevention approaches that could be used as the basis of comparison with those specific activities included in the Project Paper. However, given the relatively small amount of funding per capita (US\$1.09) for the entire six years of the project, and the potential for substantial reduction in rate of HIV transmission, the Project can per se be considered cost-effective.

Technical Constraints

There is no vaccine to prevent AIDS, nor treatment for the disease. Moreover, public health authorities in the United States and in European countries which are in the forefront of biomedical research have recently reiterated their belief that no such vaccine or treatment will be available for at least 10 years. There are also technical limitations to the accurate and early detection of HIV infection, including both false negative and false positive tests and delayed test positivity after infection. Thus, the technical capacity of governments and the private sector to prevent transmission of the virus is essentially limited to their ability to provide the general public and special populations with the information and resources necessary to take personal action to limit HIV transmission. Beyond that, they can only attempt to provide necessary and adequate palliative care in the most humane and efficient manner possible.

As was mentioned above, while drugs that can be used to effectively treat penicillin-resistant strains of STDs are available, there is some concern among specialists in the treatment of STDs that new strains of STDs may prove resistant to these drugs, and that fully effective treatment for such possible new strains may not be forthcoming in the near future.

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ANNEX F. FINANCIAL AND ECONOMIC ANALYSIS

Handbook 3 notes that health projects do not lend themselves to complex financial analysis methodologies that focus on rate of return, and include such calculations as discounted cash flow. Rather, the consideration in human infrastructure projects relates to the demand for the proposed services and identification of the most technically appropriate alternatives. Given these methodological limitations with regard to financial analysis of the AIDS/STD Project, the following considerations are presented.

The quality and quantity of health services delivered in Jamaican public facilities has been reduced by the decline in real government spending both overall and on a per capita basis during the past decade. Supplies, maintenance, and equipment replacement have been under-financed with consequent erosion in the ability of the health care system to cope with its patient care responsibilities. To illustrate, the FY1986/87 budget for the MOH was J\$382.2 million, representing a per capita expenditure on health of J\$150, an increase of J\$37 over 1985/6 in current dollars. However, using 1980 prices, the real per capita expenditure is only J\$62. As a result of devaluation of the Jamaican currency and inflation, the effective purchasing power of the MOH declined by approximately 30% since 1980.^{53/}

The Project, with a focus on surveillance and prevention as twin strategies, has the potential to significantly reduce the financial burden of AIDS and STDs on the MOH, and on individuals and families of those who are at-risk.

The estimated cost of treating an AIDS patient in the public sector in Jamaica is J\$15,000 from diagnosis to death, exclusive of indirect costs for home care and of patient expenditures for medications and treatment received through the private sector. Given an estimated average of J\$4,000 for patient expenditures (for the private health sector, including medications for symptomatic treatment) and indirect costs, the total estimated average cost of treatment per case is J\$19,000. Given the lowest estimated number of cases - 1440 by 1993 - the total cost of care would be J\$27.4 million, or 7% of the 1986/7 MOH total budget.^{54/}

An analysis of the potential for financial benefit of this Project - considering only the cost of treatment - shows the potential for a savings of J\$6.8 million in AIDS treatment costs alone by 1993, given a 25% success rate in reducing the number of cases through prevention of AIDS transmission, if the project were to be initiated in mid-1988.^{55/}

STDs are also a heavy drain on financial resources. At present, the under-financed budget of the MOH is unable to cover the costs of the urgently required contact investigators, and the more

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expensive drugs required to treat the estimated 10% penicillin-resistant gonorrhoea cases. The average treatment cost for each case of gonorrhoea is estimated at J\$42 per episode of care; with an estimated total number of cumulative cases for 1989-1993 of almost 200,000 (a 3% increase per year), a 25% prevention success rate would avert nearly J\$2 million in treatment costs. With a total of close to 34,000 estimated cumulative cases of syphilis for 1989-1993, a similar success in surveillance and prevention activities would result in a savings of approximately J\$600,000, given an estimated J\$70 cost per episode of care. For congenital syphilis, a cumulative total of 387 cases could be averted, for a savings of nearly J\$100,000 (assuming an average cost of care of J\$1,000). For treatment of severe pelvic inflammatory disease in women (PID, which is in large part a consequence of untreated gonorrhoea and chlamydia), hospitalization alone is estimated to cost J\$2,500 per episode of care (J\$164 x 14 hospital days, plus outpatient care and medication). The number of confirmed cases of PID in 1987 was 890, but the SMOH for the STD Unit estimates the total number of cases in Jamaica to be 40,000, with one in four of these requiring hospitalization; he bases these estimates on previous studies and on informal reports from both MOH and private sector physicians. This estimate of 10,000 requiring hospitalization would result in a J\$25 million hospital treatment cost for PID. Even with a minimal 2% increase, the cumulative number of cases requiring hospitalization would be over J\$54,000. A 25% success rate in prevention of severe PID would thus have the potential of saving nearly J\$34 million.

Thus, the total Project expenditure of J\$18.2 million (US\$3.35 million) will be more than offset by a savings in AIDS/STD treatment costs of J\$43.3 million (US\$8.2 million), given a relatively low estimate of the impact of improved surveillance and prevention activities.

The MOH contribution to the Project, over a six-year period, totals J\$ equivalent of about US\$850,000 which is less than one percent of the 1986/87 MOH budget. Further, this contribution is allocated for expenditures (e.g., salaries of contact investigators and critical STD treatment drugs) that should be included in recurrent MOH budget allocations. This expenditure is not considered out of line with the financial ability of the GOJ to support human infrastructure services, notwithstanding reductions in such expenditures over the past few years. According to a recent GOJ report, "the most recent economic performances (Fiscal Years 86/87 and 87/88) suggest that the pace of economic improvement has accelerated and will continue to do so, assuming no external shocks."?

With the exception of the salaries of contact investigators (which with a full additional complement of 15 would total approximately J\$444,000 by 1994, given an annual 10% inflation rate) and the supply of STD drugs (which would presumably be significantly reduced in large part through the effective surveillance and prevention activities funded through the Project), there are no substantial recurrent costs proposed that would hinder the ability of the MOH to continue to support the project activities. In any case, effective implementation of the activities in Jamaica, and effective prevention activities worldwide, will decrease the need for substantial additional expenditures.

Two important considerations in the ability of the MOH to support expanded surveillance and prevention activities are:

- the degree to which the GOJ will be committed to finance such activities (neither AIDS nor STDs were mentioned prominently in the recently-issued Social Well-Being Programme - however, this programme seeks to restore basic health infrastructure such as upgrading and renovating hospitals, health centers, and laboratories rather than implementing public health prevention programs) ^{3/}; and
- the ability of the GOJ to compete for limited external donor support which could offset the limited resources available from the GOJ. Importantly, virtually no other such donor support is currently expected for treatment of AIDS cases. This project directly addresses this issue by focusing on utilization of local resources and at the same time encouraging development of alternative sources of funding.

ACOSTRAD will, through support from the Project, be able to engender alternative donor support (both within and external to Jamaica), and will continue to undertake voluntary activities in AIDS and STD prevention, for which it has received minimal financial support thus far.

The economic (versus financial) benefits of the project are not estimated in detail since the project benefits are extremely difficult to quantify in economic terms. In general, Jamaica relies on market-oriented prices for most of the commodities to be used in the project (much of which will be imported). The exchange rate is generally market-oriented and provides relatively little distortion to resource use. Labor markets are competitive generally and nominal wages are thought to provide a reasonable estimate of labor costs (with possibly some exceptions in the health care field). Although economic benefits cannot be readily estimated, it is felt that the large financial benefits would translate into equally large economic benefits.

ANNEX G. SOCIAL SOUNDNESS ANALYSIS

1. Socio-cultural Context

Prevention of AIDS and STDs is at the core of this Project. The medical and socio-cultural complexity of AIDS renders it exceedingly difficult to design effective AIDS prevention efforts. Resource constraints compound the problem in developing countries such as Jamaica. STD prevention, although for the most part technically feasible, has proved costly, time-consuming and problematic and requires long-term, ongoing efforts.

(a) Health and Social Indicators

In 1978, the last year for which the MOH collected (rather than extrapolated) data, the infant mortality rate was 26.6/1,000 live births.^{4/} Notably, these two indicators resemble those for the Black and Hispanic population in the U.S. In 1986, life expectancy at birth for Black Americans was 69.6 years (versus 75.4 for Whites).^{5/} For infant mortality, the rate was 18.2/1,000 live births for Black Americans and 9.3/1,000 live births for White Americans.^{6/} The comparisons between minority health statistics in the U.S. and those of the Jamaican population generally are important in view of the similarities between Jamaicans and Black and Hispanic Americans in terms of life expectancy after diagnosis of AIDS and opportunistic conditions related to the disease.

The leading causes of death in Jamaica are cardiovascular accidents, heart disorders, and malignant neoplasms^{7/}, which are the same as those in the United States for the general population.^{8/} While data regarding Years of Productive Life Lost (YPLL) are not published as such, given the age-specific death rates, it appears that, as is the case in the U.S.^{9/}, accidents and adverse effects (e.g., homicides) are among the leading causes of YPLL.^{10/}

Estimated Trends of AIDS and STD Cases and HIV Seropositivity in Jamaica through 1993 - Within the context of the current economic situation in Jamaica, the already strained public health system is ill-prepared to deal with the alarming increase in cases of AIDS and certain sexually transmitted diseases, described previously. The potential for devastating socio-economic effects of these diseases, if left unchecked, is enormous.

Although the number of confirmed AIDS cases in Jamaica thus far has been relatively low in comparison with other countries, a minimum estimate of the number of cumulative AIDS cases by 1993 is 1440, assuming doubling of cases each year to 1992 and a 50%

increase in cases between 1992 and 1993 (i.e., making projections on the basis of several very optimistic assumptions).

Prevalence of STDs is high in Jamaica, and if no significant improvements in STD prevention and control are made, further increases can be anticipated. The fact that only estimated prevalence data are available renders even simple straight line projections of trends difficult and of questionable validity. However, in order to consider the future magnitude of this important health problem and its impact on the Jamaican health care system, the SMOH for the STD Unit STDs has estimated a 20% annual increase in actual prevalence of syphilis, which would result in 33,563 cumulative cases between 1989 and 1993. Given the general downward trend in estimated cases of gonorrhoea, with the exception of the small increase in 1987, the SMOH estimates only a 3% annual increase in actual prevalence of gonorrhoea, which would result in 189,775 cumulative cases between 1989 and 1993.^{11/} Although the number of cases of congenital syphilis tripled between 1985 and 1986, and then doubled in 1987, it is highly improbable that this rate of increase would continue. However, it is possible, unless screening is significantly improved and the maternal cases treated, that the cumulative number of cases will exceed 387 between 1989 and 1993, given a 20% annual increase.

(b) The Jamaican Health Care System

The Jamaican health care system is a mixed public and private system with services available by law to all Jamaicans through Ministry of Health facilities, and services by private practitioners and facilities being financed in large part through fee-for-service personal expenditures.

The most recent study of health service utilization was a household survey of some 3,000 Jamaicans in eight parishes conducted in 1987. The results of this survey indicated that nearly half of those interviewed (48%) had visited a private doctor for their most recent illness, compared with 12% visiting an MOH clinic and 14% visiting an MOH hospital. Notably, 13% had utilized home remedies, and 2% acknowledged using "other" services.^{12/} (Unfortunately, the report does not indicate if the "other" services included use of traditional healers, although this would be a reasonable assumption.)

Public Sector - The health care needs of Jamaicans are met primarily by the public sector through the Ministry of Health (MOH). The MOH is a centralized system, with the 14 parishes having limited participation in the planning, programming and budgeting process. As a result of shortages of resources, virtually no long-range planning is conducted by the MOH, although recent efforts have been made to consolidate action plans of the

individual units of the Ministry. USAID has for several years funded the Health Management Improvement Project, which was expanded in 1983 to include review and implementation of alternative financing options, support for "rationalization" of MOH facilities and personnel, and assistance in determining the most cost-effective means for providing a positive impact on national health status. As part of the HMIP, USAID has supported improvements in the MOH Management Information System, which is intended to contribute to the planning process.

The MOH is financed primarily by appropriations from the Ministry of Finance. In addition, Jamaicans pay fees for secondary and tertiary care based on rates most recently revised in 1984. The fees paid range from J\$5 for each outpatient visit to J\$50 for inpatient maternity (delivery) charges and J\$20-120 for use of the operating theater, depending on type of surgical procedure. There are no fees for family planning or immunization visits, and persons with chronic conditions such as diabetes, hypertension and mental illness pay only a J\$5 annual fee.^{13/} Only recently has the MOH been able to retain the revenue from these charges; prior to FY 1986/87, the MOH paid these fees to the Ministry of Finance.

Jamaica has a total of approximately 6,000 hospital beds, of which 95% are operated by the MOH. In addition, there is the quasi public and regional University of West Indies Hospital, located in Kingston. Hospitals are categorized as Type A, B or C: the four Type A hospitals are multi-speciality, tertiary care facilities; the five Type B hospitals have at least four of the basic types of medical specialists (medicine, surgery, obstetric/gynecological and pediatric care), and 120-200 beds; the 11 Type C hospitals provide first-level care, and have 50-120 beds each.^{14/}

In addition, the MOH operated 363 health facilities at the end of 1986.^{15/} Utilization of these outpatient facilities for curative services actually decreased from 1,137,777 visits in 1984 to 1,039,598 in 1986, while visits for preventive services increased from 805,973 to 997,928 in the same period. Home visits by MOH parish-level staff decreased by nearly 50% in the same period; this undoubtedly reflects the 50% reduction in the number of community health aides in 1984. Mental health services, which are extremely important with regard to AIDS (and HTLV-I), are minimal in Jamaica. There is one national psychiatric hospital (Bellevue) which provides both inpatient and outpatient unit, but otherwise there are virtually no public mental health services.

The Management Information System of the MOH is the focal point for health status and service statistics in Jamaica. Data are forwarded to the central level by the parishes (which in turn receive the data from the MOH facilities in their area). The data are computerized, and printouts produced. However, the data are

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not really analyzed, and summary statistics are not fed back to the parish level, nor even to Units at the central level. Moreover, vital statistics data -- critical for use by the MOH in planning programs designed to improve health status of the Jamaican population -- have collected, analyzed and reported by the Ministry of Construction since the early 1980's. The quality of these reports is highly suspect. A number of recent studies have found severe under-reporting of infant deaths, for example. ^{16/} As has been mentioned previously, STDs are also known to be under-reported. This paucity of reliable, current data results in misleading indicators of the health status of Jamaicans, and in turn has direct impact on identifying co-factors related to AIDS and STDs in Jamaica, which inhibits effect policy and program planning.

The Epidemiology Unit collects data from each of the parishes independently of the Management Information System, and produces quarterly reports of notifiable diseases. The STD Unit collects data from the parish level (although not all parishes have reported in the past several years), and produces annual reports of STDs. However, these reports are severely limited by the under-reporting of even Class 1 notifiable diseases by both public and private sector physicians.

Private Sector - The private health sector in Jamaica is comprised of four hospitals with a total of 238 beds.^{17/} According to the PAHO report on hospital restoration, only about 1% of all hospital discharges in Jamaica are through the private hospitals. This is in line with the utilization data resulting from the 1987 household survey, which showed that less than 1% of those interviewed had visited a private hospital for their most recent illness. In preparation for this Project Paper, data from that same survey were calculated to show costs of treatment for the most recent illness of the respondents. The survey report does not specify whether the costs were incurred at public or private facilities, or a combination thereof, but does state that costs are for the episode of care en toto, rather than for each utilization of service. The summary calculations show that total costs for the most recent episode of care were under J\$50 for 44% of those interviewed, between J\$50 - J\$100 for 33% of those interviewed, and between J\$100 - J\$150 for 11% of those interviewed. It appears from the report that these represent costs to the patient only; that is, they do not include any applicable third party payer reimbursements.

Fee-for-service charges for private consultations are said to range from US\$5 to US\$50, depending on the specialty and socio-economic class of the physician and patient. According to a study of health services utilization conducted in 1981, about 40% of the population use private practitioners.^{18/} The Planning

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Institute of Jamaica recently published a report that showed that an average of 2.2% of expendable income per capita was used for medical care in 1984.^{19/}

Private Insurance Coverage - According to the 1987 household survey referenced above, 12% of respondents participate in some form of private health financing scheme. Of these, more than half (51%) were covered through a private health insurance plan, 24% by another type of plan, and 21% by a plan that was at least partly employer or company financed.^{20/} If these survey results can be generalized to the population at large, then there have not been any changes in coverage since 1981, when the most recent national survey of health insurance coverage was conducted. According to that survey, just under 13% of the population had private health insurance coverage, and of these, only 30% submitted a claim to their insurer for their most recent use of health care.^{21/}

However, according to a report of the private insurers^{22/}, 110,000 employed persons were enrolled in private health insurance plans in 1984. Sixty percent of these employees paid additional fees to cover their family's health expenditures. Importantly for AIDS, most of the private health insurance companies require physical examinations prior to coverage and screen for HIV seropositivity for persons suspected of being at-risk for AIDS.

2. Beneficiaries

The target population for AIDS prevention, as defined by the World Health Organization, the U.S. Public Health Service, and the GOJ, is the general population. For Jamaica, in addition to the general population (of 2.3 million in 1987), the groups which have been defined as most at-risk -- with estimated numbers of each -- are prostitutes (1,000), migrant farmworkers (10,000), higglers (2,000) and men engaging in regular or occasional homosexual practice (11,000), and the sexual partners of these individuals. For purposes of this Project, we have also defined women of child-bearing age and adolescents as important target populations, the former because of the high rate of pediatric cases of AIDS in Jamaica thus far, and the latter because of the high rates of STDs in the age group for the past several years. Further, a particular focus of the targeted prevention activities with regard to both AIDS and STDs will be identifying means of access to lower socio-economic groups, particularly those with less access to MOH and private health care facilities, and those who are illiterate.

The direct beneficiaries of the project include:

- the MOH, ACOSTRAD and other public and private sector personnel who will be trained in AIDS and STD surveillance and prevention;

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- the community-level participants who will be involved in AIDS and STD prevention activities, including national, regional and local public conferences and expositions, formal and informal meetings organized through the project, information and education programs conducted by community groups (e.g., educational theater productions);
- individuals who are currently infected with HIV or STDs and who will be tested and provided counseling and other support directly through the project, and receive treatment provided by personnel trained through the project; and
- sexual partners of the above individuals who may not become infected as a result of changes in sexual practices on the part of the above due to counseling and information dissemination funded by the project.
- As women of child-bearing age will be a target group, children born to women who are at-risk (e.g., prostitutes, sexual partners of infected men) will also be direct beneficiaries. The high rate of pediatric cases of AIDS and of congenital syphilis in Jamaica make children born to the high-risk women, and particularly to infected mothers, an important beneficiary group.

Indirect beneficiaries include all those who are in at-risk populations (with respect to AIDS) or who are sexual partners of at-risk individuals, and all Jamaicans who are at risk for STDs by virtue of being sexually active.

Assuming that neither the MOH nor ACOSTRAD implements any of the Project activities in such a manner as to violate basic principals of bio-ethics (including those concerned with the conduct of research on human subjects), there are no categories of people or groups who are likely to be adversely affected by project activities.

The GOJ (through the MOH) was one of the first countries in the LAC region to have available a short-term plan for AIDS, and is presently preparing its medium-term plan. It has evidenced a commitment to this project by making available the critical MOH personnel for Project planning meetings and providing requisite data for use in project development.

The activities included in the project are directed toward the general public (without regard to socio-economic class), to target groups most at-risk for AIDS and STDs, and to lower socio-economic classes who may be less positively influenced by mass media campaigns by virtue of their illiteracy, access to radio and television, or other factors.

3. Participation

Key representatives of both the MOH and ACOSTRAD were involved in Project development from the outset, including review of drafts of the Project Paper and discussions of alternative approaches to project mechanisms. In addition, the Project Design Consultant met with representatives of community organizations that could potentially be involved in project implementation (e.g., religious leaders, Sistren, the Optimists Club) and members of high-risk groups (prostitutes and homosexual and bisexual men). This is in addition to those with whom she met on an earlier site visit (in September, 1987), and from whom she gathered information and recommendations that were taken into account in development of the Project Paper.

Jamaica has a long and enviable history of national, parish and local level organizations and groups' working for and with local communities on a variety of social problems. The organizations range from churches to the Jamaican Agricultural Society, the Scouts, YMCA and YWCA, and entrepreneur-based service clubs such as the Optimists Clubs and Kiwanis. All of the private organizations mentioned, in particular those with experience in community participation, are potential vehicles for dissemination of AIDS and STD prevention information. In addition, in view of the importance of music to Jamaican society, and the influence of both reggae stars and disk jockeys, popular recording artists, record companies, and music broadcasters are a potential resource. Notably, a few of the popular reggae groups have recorded songs that carry anti-drug, anti-AIDS, and anti-STDs messages, some of them with support and assistance from ACOSTRAD. There is also the potential to involve private sector advertising agencies in developing and producing mass media messages.

While no specific structure for community participation has been established through the Project, both the head of the MOH AIDS Program and the Chairman of ACOSTRAD are experienced and interested in community participation in health planning and program implementation.

4. Socio-cultural Feasibility

The following are perceived as the primary implementation obstacles that may arise from socio-cultural forces that pertain in Jamaica and that could influence effective AIDS/STD prevention. It should be pointed out that they are not exclusive to Jamaica, but rather have been experienced in virtually all countries to a greater or lesser extent, particularly as a

consequence of increased public concern with regard to the AIDS epidemic. Some key obstacles are:

- socio-cultural taboos concerning homosexual practices, and the consequent "closeting" of homosexuals in bisexual relationships (these affect the degree to which such individuals are receptive to prevention messages, and the likelihood that they will trust MOH or private testing facilities sufficiently to request the HIV test;
- socio-cultural (particularly religious) influences with regard to use of any form of birth control method, which would hinder the acceptance and use of condoms, a proven effective method of reducing AIDS and STD transmission;
- economic barriers to private sector health care facilities and personnel; and
- the relatively high rate of illiteracy, which obviates the utility of disseminating printed information to those in the lower socio-economic classes.

5. Impact

As has been discussed in the Project Paper, the project is expected to have significant impact in terms of reducing the projected transmission of AIDS and STDs. This will have impact throughout the population as a result of decreased personal (financial) cost, as well as lessened human suffering.

It is likely that the activities implemented successfully in Jamaica can be replicated not only in other English-speaking Caribbean countries, and in other countries in the Latin American/Caribbean region, but importantly that they could be replicated among the Jamaican population residing in the U.S. Given the keen interest of both the public and private sectors in Jamaica in the AIDS/STD Project, it is anticipated that activities will continue beyond the life of the Project, to the extent that they are necessary and appropriate.

Although it is probable that all activities will be equitably implemented among all affected groups, given the socio-cultural obstacles mentioned above, it is impossible to assure that all benefits (i.e., improvements in outcome indicators such as those included in the Logframe as EOPS) will be equitably distributed.

6. Issues

The AIDS epidemic has raised issues that most members of the general public - and health professionals - would rather not

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face. These include the prevalence of and societal reactions to sexual practices which place the persons involved at relatively high risk for AIDS, fear of so-called "dread diseases" (which until recently in the U.S. included cancer), and fear of death and dying. In Jamaica, which has strong religious and cultural taboos against homosexuals and bisexuals, it is even more difficult to implement effective AIDS prevention and intervention programs. However, extensive focused interviews have indicated that the strategies and activities outlined in this Project Paper are feasible and socially sound and that they are unlikely to encounter significant and effective opposition by raising these issues. The strategy of directing a sub-campaign on AIDS education and prevention toward the high risk groups will enable the project to assure their ready access to information of special relevance and importance to them without unnecessarily generating opposition.

The current inability of the MOH to adequately collect and maintain surveillance data which is critical to AIDS and STD program planning has been discussed elsewhere, and will be significantly improved through this Project. It must be noted, however, that given the nature of AIDS and societal reaction to it, governments throughout the world are debating the ethical boundaries between information necessary for public health purposes and the individual's right to privacy. This will be of continuing concern throughout the life of the Project.

The ability of the Project to result in the EOPS shown in the Logframe is contingent in large part on changes in sexual practices (e.g., safe sex practices), over which the GOJ certainly has no control. However, AIDS prevention experience in the US and elsewhere has shown that clear educational programs that include counseling have significant impact on the behavior of individuals. Furthermore, individual reports on the part of members of one risk group in Jamaica (homosexual and bisexual men) indicate that some are engaging in safe sex practices already, as a result of general knowledge of the dangers of AIDS as well as information provided by the MOH or received from the U.S. Prostitutes have also reported that they are increasingly using condoms as a means of protection.

ANNEX H. ADMINISTRATIVE ANALYSIS

Primary responsibility for implementing the Project will reside with the Project Manager, who will be placed in the Epidemiology Unit, along with the Operations Research Specialist and the Communications Specialist. The Project Manager will liaise as necessary with other units in the MOH, specifically the STD Unit and other Primary Health Care Units. The services and expertise of ACOSTRAD will be called upon through the mechanism of a sub-grant.

The Administrative Analysis describes both the MOH (Public Health Sector), and ACOSTRAD and the National AIDS Committee (Private Sector).

1. THE PUBLIC HEALTH SECTOR

The health care needs of Jamaicans are met primarily by the public sector through the MOH. The MOH is a centralized system, with the 14 parishes having minimal participation in the planning, programming, and budgeting process. As a result of shortages of resources, virtually no long-range planning is conducted by the MOH, although recent efforts to do so have been made.

The Medical Officer of Health in each of the 14 parishes is responsible for managing the delivery of health services as well as for maintaining and reporting epidemiologic and service data. He/she is also responsible for epidemiologic follow-up in the case of STDs (including AIDS); in the latter case assistance is provided by contact investigators and nurses working at the parish level.

At present, the MOH is subject to severe constraints, as outlined below. These overall constraints also affect its ability to effectively and efficiently undertake surveillance and prevention strategies with regard to AIDS and STDs. Working in conjunction with the existing primary health care network and hospital system, the Project will work to reduce the negative impact of those constraints.

The sections below describe the structural constraints within the Jamaican civil service and the impact these have on the efficient operation of the MOH. An overview is then given of some reform measures that are being undertaken by the GOJ and management innovations being implemented by the MOH.

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A. Fiscal Control

The MOH Finance Division is responsible for budgeting and fiscal control. In the hospital network budgets are set at the regional level, with some involvement of the hospital boards. In the PHC network medical officers initiate the budgets for the health centers in their parishes. In the best of circumstances, the health committees for individual centers provide some input in the process. The formal procedure begins with the medical officers presenting to MOH/Kingston a consolidated budget for the entire parish. Traditionally, this has been a "line item" budget for such categories as salaries, rent, utilities, and medical supplies. Individual hospital region and parish budgets are reviewed in Kingston by the appropriate principal medical officer and forwarded to the Finance Division. A budget committee, which includes the Permanent Secretary, Chief Medical Officer, heads of various administrative departments, and the chief of the medical services involved (PHC or hospitals), reviews the budgets. The Finance Division prepares a consolidated budget for the entire Ministry. Recurrent cost budgets are reviewed and negotiated with the MOFP; budgets for capital expenditures are reviewed and approved by the Prime Minister's office. The Minister of Health presents and defends the budget in Parliament.

An initial advance, or "warrant," is forwarded to each hospital regional and parish. Subsequent monthly payments are contingent upon receiving a reconciliation of the previous payment. The rationale for this monthly release and reconciliation procedure is that the scarcity of funds precludes a more phased system. The lack of flexibility on the part of MOH financial managers is also a function of the tight management control retained by the MOFP.

Under British colonial rule medical service was something that was provided, with little thought given to the cost of care, efficiencies in service delivery, savings in curative care resulting from effective PHC, or comparative costs of competing services (immunization vs. safe water). In the past few years, however, Jamaica has learned that public services do have a cost and that no system can provide all things to all people. This has precipitated some sound, and politically courageous, decisions on the allocation of scarce resources to the health sector.

For example, in response to a pilot study demonstrating that different mixes of clinic personnel could more efficiently handle the patient load ^{23/}, a project is planned to see if savings can actually be generated by restaffing clinics based on more efficient patterns of utilization. However, since the MOFP retains such tight control over the allocation of finances and the MPS has authority over personnel positions and classifications, the MOH must fight for the authority to realign staff and budgets

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to maximize service per cost. The Administrative Reform Programme (ARP), a government-wide program designed to address constraints on the operation of the civil service, could clearly be an ally in helping the MOH gain this authority.

B. Personnel System

1. Recruiting and Retaining Staff - Serious problems for the MOH are the recruiting and retaining of management staff and medical and technical specialists. Although this problem is not unique to the MOH, it clearly affects the fulfillment of the Ministry's mandate.

The repeated criticisms of the operation of the MOH can be traced in large part to staff vacancies. At any point in 1987, from one-quarter to one-third of the required medical positions were unfilled. The problem of unfilled vacancies is directly linked to the issue of over-centralization in the GOJ. This manifests itself at the level of both the line ministry -- MOH -- and the core ministries, particularly the MOFP, the MPS, and the independent Office of the Services Commission (OSC) of the Personal Services Commission. For example, when a Type I health center in a rural area requires a nurse, the request must be approved by the Director of Nursing at MOH headquarters. The Director of Nursing and the Personnel Department identify and interview suitable candidates. However, the MPS is the only ministry currently authorized to approve a position, and the OSC is the only body authorized to hire. Moreover, the MOFP must agree to fund the position even if the slot has been approved by the MPS. Therefore, the MOH staff must (a) receive approval from the MPS for the position, (b) receive authorization from the MOFP to fund the position, and (c) receive approval from the OSC to hire the individual. The process is time consuming and deprives the MOH of the authority to make personnel management decisions.

A similar circumlocution is required when the MOH wants to dismiss a person for cause. The MOH must request an "interdiction" from the OSC on the employee judged to be derelict. The OSC makes a judgement suspension. The OSC then hears and decides every case in the government, a process that can take over a year. The practical effect, according to informal reports by MOH staff, is that many supervisors simply do not take action against non-performing employees because it is not worth the effort. This undermines supervisory responsibility and promotes low productivity and low morale.

The important point to note, however, is that this is not an MOH problem; it is a GOJ problem. The MOH simply illustrates the problems that accrue from over-centralization of management and personnel functions.

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2. Salary Levels - Perhaps the single greatest obstacle to recruiting and retaining high caliber staff is the low salary levels of the Jamaican civil service. A study in 1983 by Technical and Economic Development Associates documented that all civil service salaries are low, but that the remuneration of professional managers is proportionately lower than for technical staff^{24/}. A target of the ARP is therefore to raise the salaries of civil servants. In the past two years:

- Executive management staff received a one-time increase of over 20%.
- The senior management group and the top grades in the medical fields received a one-time increase of over 10%.
- Executive management and senior management staff received another 7% increase on 1 October 1987, retroactive to 1 July.
- Administrators, financial managers, and natural and applied science groups received an increase of 8-12 1/2% on 1 October 1987, retroactive to 1 July.
- Clerical and support staff received a 13 1/2% increase, also retroactive to 1 July.

Another component of the ARP is the process of "reclassification", or redrawing the competency levels and salary grades for civil service positions. This is an opportunity for the MOH to aggressively pursue the upgrading of managerial positions and to ensure that technical medical specialties are categorized at a level congruent with training and skill levels.

3. Personnel Coverage - With shortages at virtually every facility in the MOH system there is little or no room for "backup". Leave days, departmental leave, sick leave, and bank holidays total 65 days a year (13 weeks) for government employees. The result is that civil service workers have 3 months of leave per year. This means a significant number of vacant posts at every point during the year.

A recent article in the West Indies Medical Journal indicates that the greatest percentage of "unproductive" time in observed clinics is due to absenteeism^{25/}. Medical officers' total "unproductive" time was measured at 35%; for dentists the total was 69%. The authors explain that a significant proportion of this "absent" time may be due to circumstances beyond the control of the medical staff, e.g., non-functioning equipment. That is only an index, however, of another breakdown in the management system of the MOH -- a breakdown that is correctable within the present authority of the Ministry.

C. Administrative Support Systems

A serious problem for the MOH is the weak performance of its management support systems: vehicle maintenance, equipment repair, and drug logistics. Inventory controls and performance monitoring do not appear to be in place. Long lead times required by the MOH procurement process make it difficult to accurately anticipate future commodity needs. This problem is compounded by insufficient funds to purchase equipment and supplies, leading to a scarcity of spare parts, frequent breakdowns due to lack of preventive maintenance, and depletion of basic health center supplies. Inadequate transportation is the focus of the most attention during discussions with field staff. Vehicles are not readily available when health center staff need to make home visits. A further frustration is the lack of coordination between the PHC network and the hospital system; there is no reciprocal access to vehicles, even with sufficient justification.

D. MOH Management Innovations

The MOH is currently in the process of undergoing some management changes that have the potential to significantly streamline operations and focus the Ministry on its role and objectives. These changes involve broad policy alternatives as well as day-to-day operational procedures. They include: rationalization, integration/decentralization, and performance budgeting.

1. Rationalization - "Rationalization" is the term that has been applied to the reappraisal of hospital utilization, particularly of small rural hospitals that are relatively costly to operate but that have low utilization rates. The result of this process has been the managerially efficient, but politically difficult, decision to downgrade five small secondary care hospitals into "polyclinics". These will become type III health centers with the added feature of lying-in facilities for normal deliveries. Significant savings in recurrent costs and staff have already been demonstrated.

To balance the services lost from downgrading five hospitals, selected other hospitals will have beds added without increasing the basic range of services now given. Polyclinics will refer patients who require hospitalization to these expanded facilities, designed "receiving hospitals".

A third component is the upgrading of some highly-utilized hospitals. Specialty services to be added include radiology, physiotherapy, ophthalmology, and laboratory support.

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2. Integration/decentralization - The MOH is very aware of the fact that operational decision making is concentrated in Kingston. In addition, it is recognized that what has emerged as a two-part system - PHC and secondary care hospitals -- has a number of problems. Management functions and personnel are duplicated in the two independently operated systems. Coordination is also inhibited, and referrals from health centers to hospitals are not smooth. Frequently, patients go to hospitals for routine primary health care that the system is designed to provide in health centers. The process is further confused by the fact that the jurisdictions for PHC do not coincide with the ten hospital regions.

The MOH has started to address these problems through a two-part change in management aimed at: (1) merging the parallel PHC and hospital systems -- integration -- and (2) delegating more authority, and responsibility, to managers at the area level -- decentralization. For example, in the PHC system groups of parishes are being merged as "health areas" for the delivery of PHC services. One pilot area has been created and another is being formed. There have been discussions that a PHC/hospital health area could eventually be managed under the direction of a single area health director.

3. Performance Budgeting - An important tool in the process of decentralization and integration will be the performance budgeting. The area health directors, who are closest to the action, will be expected to monitor the achievement of present goals, within budget limits, for their respective areas. They will therefor gain both the authority and the responsibility to efficiently implement the MOH program.

Ultimately, the MOH would like the authority to make management decisions on the type of service mix and personnel required to implement its program in the most efficient manner. Information from the PRICOR operations study would be utilized for such decision making^{26/}. At the moment, however, the ministry does not have the authority from the MOFP, the MPS, or the OSC to operate the program in such a manner.

II. PRIVATE SECTOR

ACOSTRAD is a private voluntary, non-profit organization which was founded in 1978. The main aim of the founders was to create a broad-based organization to support the government's STD control program through the promotion of education among the people. As far as possible, ACOSTRAD works through existing agencies and community groups. ACOSTRAD is headed by an Executive Committee consisting of persons from public and private sector

organizations. Although ACOSTRAD has been the recipient of various project related grants, it does not employ full-time permanent staff, but rather depends on voluntary professional and administrative personnel. Current funding sources are grants, and nominal membership dues. Accordingly, the Project will need to develop ACOSTRAD as an organization which has the proper managerial and financial systems in place for it to become a viable entity in the long run. Given the fact that AIDS/STD prevention and control requires long term efforts involving private and public sector organizations, the institutional development of ACOSTRAD is an essential component of the Project.

The National AIDS Committee is a newly created committee which will advise the Ministry of Health on activities relating to the prevention and control of AIDS. It does not currently have the legal status which would enable it to be a sub-grantee under the Project. However, given the long term nature of the AIDS problem, the Government may at some point choose to elevate the Committee to an organizational status which will allow it to implement selected activities of the National AIDS Control Program. If this is the case, and if requested by the Government, USAID will consider the organization as a sub-grantee/contractor under the Project.

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ENVIRONMENTAL THRESHOLD DECISION

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AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON D C 20523

LAC-IEE-88-31

ENVIRONMENTAL THRESHOLD DECISION

Project Location : Jamaica

Project Title : AIDS/STD Prevention and Control

Project Number : 532-0153

Funding : \$2,500,000

Life of Project : 6 years

IEE Prepared by : Charles Matthews
USAID/Kingston

Recommended Threshold Decision : Categorical Exclusion

Bureau Threshold Decision : Concur with Recommendation

Comments : None

Copy to : William Joslin, Director
USAID/Kingston

Copy to : Andre DeGeorges, RDO/C

Copy to : Charles Matthews, USAID/Kingston

Copy to : Patricia Buckles, LAC/DR/CAR

Copy to : IEE File

James S. Hester Date JUL 29 1988

James S. Hester
Chief Environmental Officer
Bureau for Latin America
and the Caribbean

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ENVIRONMENTAL DETERMINATION

Program: Jamaica
 Title: AIDS/STD Prevention and Control Project
 Number: 532-0153
 Funding Source: DA, Health and AIDS
 Proposed Obligation: FY 1988
 LOP Funding: \$2,500,000
 Proposed LOP: 6 years
 Mission Determination: CATEGORICAL EXCLUSION
 Prepared By: Charles R. Mathews,
 Mission Environmental Officer *Charles R. Mathews*

A. Activity Description: The proposed activity will seek to improve the health status of the Jamaican people (Goal). The purpose of the project is to reduce HIV transmission and the incidence and prevalence of Sexually Transmitted Diseases in Jamaica. Through improved surveillance, prevention activities, and institutional strengthening, the Project will increase the prevention and control of AIDS and sexually transmitted diseases.

Proposed Project activities do not contemplate any construction or other influence on the natural or physical environment.

B. Discussion: Implementation of the proposed project activities will involve technical assistance, training, operations research, and some commodity procurement which, when weighed against the criteria in Section 216.2 (c) (1) and (2) of AID's Environmental Procedures, are considered to qualify for a Categorical Exclusion for which an Initial Environmental Examination is generally not required.

This statement is submitted for Bureau Environmental officer review in accordance with Section 216.2 (3).

C. Approval

Approved: *TR Tiff*

Disapproved: _____

Date: 7/18/88

Thomas R. Tiff
 Acting Mission Director
 USAID/Jamaica

ANNEXES
End Notes

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